MEDICARE AND MEDICAID CONTRACTING

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COMBINING MEDICARE PART A AND PART B UNDER
A SINGLE CONTRACTOR

I. Statement of the Issue

Should Medicare continue its present mode of contracting along program lines (Part A--intermediaries servicing hospitals, skilled nursing facilities (SNFs), home health agencies (HHAs), etc., and Part B--carriers servicing physicians), or should it contract along functional lines (claims processing, beneficiary services, audit and reimbursement).

A major consideration in addressing this issue is the potential for improving overall program administration. Some of the major concerns relate to the need for reducing administrative complexity, providing for more effective communication and service to the provider and beneficiary communities, achieving more consistent application of policy where the same benefits are now being administered by intermediaries and carriers, gaining more effective control and coordination in the utilization area with Professional Standards Review Organizations (PSROs), improving the coordination and exchange of information with Medicaid and other agencies, reducing and consolidating the number of contractors, providing the framework for more effective and consistent application of program requirements, and establishing a structure in which future program changes and policy emphasis, particularly in a cost containment environment, can be more effectively carried out.

II. Discussion of the Issue

In 1965 when the Medicare program was enacted, the Government adopted a program alignment similar to that used by Blue Cross/ Blue Shield Associations in furnishing services to their membership. Intermediaries, (Blue Cross Plans) serviced hospitals, SNFs, etc., and carriers, (Blue Shield Plans) services physicians, laboratories, etc., The adoption of this structure helped insure a smooth implementation and was compatible with the historical pattern of administration used by the industry. The emphasis in 1965 was to quickly implement the Medicare program and make its administration efficient and effective.

As part of the administrative arrangement, the Government, under Section 1842 of the Act, assigned geographic service areas to a mix of private and public insurance companies (carriers) to handle physician services. However, through the influence of the American Medical Association (AMA), American Hospital Association (AHA), and Blue Cross Association (BCA), a nomination process was enacted under Section 1816(a) of the Act for dealing with hospitals, skilled nursing facilities and HHAs. Under this provision, a group or

association of providers designates an intermediary through whom they wish to deal with the Government. Upon notice to the Secretary, the provider may change the intermediary; thus, the provider has the flexibility to "shop" for an intermediary that meets its needs. The Government could terminate the service of an intermediary or not renew the contract; however, until recently, the Government could not assign the providers to a particular intermediary, since to do so would violate their legal rights under the nomination provision.

Under the provisions of Section 14 of Public Law 95-142, new authority has been established so that providers may be assigned or reassigned to intermediaries when the Secretary finds that it is in the best interest of effective and efficient program administration. The adversely affected intermediary has an appeal right when its providers are reassigned by the Secretary. The appeal may delay the reassignment of a provider. However, in any reconfiguration of Part A contractors, the issue of assigning and reassigning providers must be addressed. This issue applies to pure Part A workload reconfiguration, as well as Part A & B combinations, or Title XVIII-XIX integration. Thus, legislative changes in the nomination process will be needed.

As indicated above, the Medicare Bureau has been using contractors to perform administrative functions based on the type of provider of services the contractor traditionally serviced--intermediaries servicing hospitals, SNFs, HHAs, and carriers servicing primarily physicians. Though the intermediaries and carriers service different types of providers, they basically perform similar functions. Both types of contractors receive and process claims, make reimbursement payments, and handle beneficiary inquiries. The major functional difference is in the provider reimbursement and audit area, which is unique to intermediaries. However, since there are common functional areas for both intermediaries and carriers, the concept of combining similar functions within a single contractor needs to be considered. Contractors would not specialize by provider, but, rather, by function, e.g., claims processing, beneficiary services, interim payment, or final settlement. This paper sets forth options and recommendations for combining Part A and Part B under a single Medicare contractor.

In addressing the Part A and Part B Medicare combined contract, a number of issues should be kept in mind. First, the nomination process and the legislative base for contracting needs to be changed. Second, the combined Part A and Part B contract may not be compatible with present geographic areas, and may require some shifting of workloads, which may cause disruption to the program. Third, some contractors lack experience in either Part A or Part B, and could be reluctant to pursue the combined contract as a corporate

line of business. For example, Part B contractors may not be experienced in audit and reimbursement on a cost basis. Fourth, the final form for National Health Insurance (NHI) has not been determined. For example, if provider reimbursement is based on State rate setting authority, then much of the final settlement process would be altered, and the degree of Federal involvement would change. At the present time, the final form for NHI, and its related impact on contractor activities, cannot be predicted.

In developing alternatives to the present contractor arrangement, it is important to be cognizant of the timing of a change. Current contractors and the entire marketplace need time to respond to function changes proposed by the Government. They need to review changes in light of corporate objectives, resources, and ability to satisfactorily perform. They also need time to change operating systems, including software packages, and train staff. The Federal Government needs time to modify its administrative processes to insure effective contract administration, monitoring and evaluation.

III. Summary of Options

- Continue the present arrangement of contracting with intermediaries and carriers along Part A and Part B program lines.

- Change the entire country based on geographic realignment to a combined Part A and Part B contractor, while keeping separate Part A and Part B program operations.

- Change the entire country based on geographic realignment to a combined Part A and Part B contractor with integrated program operations along functional lines, e.g., claims processing, beneficiary and provider services, provider reimbursement and audit.

- Acquire legislation which permits the Secretary to combine Part A and Part B under a single contractor while conducting experiments to test the feasibility of such an arrangement.

- Conduct studies and experiments to test the relative advantages and disadvantages of a combined Part A and Part B approach.

IV. Discussion of Individual Options

Option 1: Continue present arrangement

This option is to continue the Part A and Part B program identity

of intermediaries and carriers, thereby allowing them to specialize in servicing various classes of providers and the beneficiary. Health Care Financing Administration's (HCFA) continuous efforts to simplify the program and provide more effective contract administration when applied to the present contract arrangement, may produce early returns, while substantial changes in the Part A and B contractor arrangements could possibly delay some of these initiatives. Some examples of these initiatives include consolidation of workloads along geographic and service area lines and improved cost performance via the increased use of competition (e.g., Illinois, New York experiments), improved operations via the use of performance criteria and standards (e.g., Part A Quality Assurance Program), and more effective contract monitoring and evaluation (e.g., product rather than process evaluation). These same objectives may be pursued in a different environment, but efforts and priorities would need to be modified.

Advantages

This option provides continuity by maintaining existing communication lines and relationships established between the Medicare Bureau, the contractor, the provider, and the beneficiary. It provides a solid base for making immediate improvements along program lines. It also provides time for the contractor community to prepare itself for future changes. Contractors need lead time to change corporate policies, evaluate risk situations, develop new systems, etc.

The present legislative base could be used, and Section 14 of Public Law 95-142 could be tested before seeking new legislation. HCFA staff would be free to improve present structure, as well as address other areas designated for change. It leaves open the option to change to some other contract arrangement, e.g., a different functional arrangement. Additionally, the present system is proven and works, whereas proposed changes may not be as effective, given the same level of effort.

Disadvantages

Since not all present contractors serve as both an intermediary and carrier, program administration can be encumbered in such areas as data transfer. Beneficiaries must use several contact points when dealing with the Government representatives. The present contractor arrangement may not be optimum for future legislative changes and program initiatives.

Costs/Savings

If the present contractor arrangements are maintained and improvements introduced, cost savings may be achieved through increased productivity, increased competitive procurement activity, improved program procedure.

Option 2: Change to a single contract now, but keep separate Part A and Part B program operations

This option is to change from the separate Part A and separate Part B contracts to a combined single contract for Part A and Part B. Although a single contract would be used, the contractor would retain separate program operations for Part A and Part B. At the present time, the change from the separate contracts to a single contract for both Part A and Part B could be executed with a number of contractors, primarily Blue Cross/Blue Shield Plans now serving Part A and Part B respectively in the same State. However, in these cases, there may be some corporate charter, or State law provision that may impede a single contractual arrangement. It may be necessary to reassign geographic service areas, and/or providers to a significant degree to accomplish the objective of single Part A and B contracts.

Advantages

This option would provide an interim step for possible further Part A and Part B program integration under a combined contractor. It would encourage contractors to seek both program lines of business, and combine their internal operations. Realignment may be more compatible for future program changes.

Disadvantages

This option would further fragment contractor arrangements, i.e., separate Part A contracts, separate Part B contracts, and combined Part A and B contracts. It may disadvantage commercial insurance companies since they do not handle both program lines in a single geographic locality. It would require significant redistribution of intermediary and carrier workloads to create contractors servicing both program lines. Such redistribution could cause considerable disruption to providers, and particularly, beneficiaries. Beneficiaries would have to cope with several changes, including, but not limited to, increased difficulty in long-term claims disputes, and possible delay in processing of complementary Blue Cross-Blue Shield insurance. Also, if physicians drop assignment due to the disruption, beneficiaries could be paying more for services. This realignment of contractors could result in higher total costs to the program and loss of continuity in program

integrity cases. Finally, a realignment of this magnitude would require legislative change.

Costs/Savings

No appreciable cost savings are identifiable with this option.

Steps Required for Implementation

Implementation would require legislative changes to clarify and overcome present constraints in Sections 1816 and 1842 of the Act, especially with respect to the nomination process under Part A. For those contractors who do not presently handle both program lines (Part A and Part B), a decision on whether to reassign workloads, or to use three types of contractors must be made. Workloads may need shifting if it is decided to combine Part A and B contracts. HCFA will need to modify its performance standards, contractor monitoring procedures and evaluation criteria for the combined contract mode.

Timetable

	Legislative Change	
	Not Required	Required
Change legislative base	N/A	10/1/80
Single contract for present Part A & B contractor	10/1/80	10/1/81
Workload reassignment option (four years after change in legislation)		1985

Feasibility

Legislative Considerations

Full implementation of this option would require legislation. Partial implementation could occur in those situations where the same contractor now serves as both the intermediary and carrier.

Administrative Considerations

A single contract with only those contractors presently handling both Part A and Part B would contribute little to improved program administration and would further fragment the variations in types

of contracts. Present administrative procedures dealing with contract monitoring and evaluation would remain the same. If the decision is to have single A and B contracts for all contractors, then it becomes a problem in terms of (1) how much workload to shift; (2) how to select the recipient and donor contractors; and (3) how to maintain effective administration during the transition phase.

Budgetary Considerations

There would be no significant budget impact if a single contract is used with present contractors; however, if substantial workloads are shifted, administrative budgets will increase, rather than decrease, because of start up and phase out costs. Ongoing operating cost may level off since recipient contractors will be less efficient for a period of time than the departing contractor.

Political/Social Considerations

Where present Part A and B contractors agree to a single contractual arrangement there would be minimal political and social impact. One exception may be in the area of the nomination process. Attempts to diminish this provider right will stimulate them to support the status quo via their influence with administration and congressional contacts.

Option 3: Combine Part A and B under a single contractor with integrated program operations along functional lines

This option is to change from the separate Part A and separate Part B contractor to a single contractor for Part A and B, with the provision that program operations be integrated along functional lines. This option is based on the assumption that similar Part A and Part B functions can be combined: claims processing functions, beneficiary and provider service functions, etc. The contract for all the functions could be let to any organization which qualifies and wins the bid. Or, the unique functions of Part A, such as provider reimbursement, audit and cost settlement could be considered for a separate contract. With two contracts, one for the claims processing functions, and the other for the reimbursement and audit functions, there would be no compelling reason why both contracts would be with the same company. In fact, it is envisioned that accounting firms could perform reimbursement and audit functions, and traditional intermediary and carrier type companies could process claims. A change, at this time, to a single Part A and B contract for all present and future contractors would require a change in the legislation regarding the nomination process, and massive workload shifts to reduce the number of existing contractors.

Advantages

This option would provide better coordination and flow of information on program activity. It would provide better utilization review and control of program payments by establishing single beneficiary data bases. It would also give the Medicare beneficiary a single contact point. Furthermore, it would facilitate implementing future program policy and legislative changes.

Disadvantages

Shifting large workloads may cause disruption to beneficiaries and providers during the implementation phase. For example: (1) there may be a new telephone number to call for inquiries; (2) with a changeover of carrier personnel, the difficulty of resolving long-term problems may be increased; (3) the processing of all forms of complementary insurance may be delayed. The disruption to the physician during the implementation phase may cause him to no longer accept assignment, thus shifting costs to the beneficiary. Finally, a changeover in contractors may result in short run increases in total costs to the program, loss of jobs for personnel in the former contractor's office, and a loss of continuity in program integrity cases. In addition, the industry is not prepared for an immediate functional change, so that unless a major change were phased in over a period of time, it could foster a monopoly or oligopoly.

Costs/Savings

During the transition phase, administrative costs would increase due to start up and phase out costs. However, in the long term, significant administrative cost savings could be anticipated from the substantial reduction in the number of contractors which would occur. The opportunity for more effective monitoring and control over program payments should support savings in benefit monies.

Steps Required for Implementation

Secure necessary changes in legislation. Develop detailed implementation plan and strategy to implement the option on a phase-in basis. Develop criteria for shifting workload to contractors servicing only a single program line; modify performance criteria, contract monitoring procedures, and evaluation criteria.

Timetable

Legislative changes	(10/1/81)
All combined contracts in effect	(1985)

Feasibility

Legislative Considerations

The process to secure the necessary legislative change may be long and difficult because it diminishes the power, influence and options available to organizations such as BCA, contractors and providers.

Administrative Considerations

Changing to a single contractor will require the formulation of a strategy to implement the change, an approach for selecting contractors to service areas, a methodology to identify ideal service areas, and the modification to the present contractor monitoring and evaluation process. Existing administrative processes would have to be modified to handle the single contract mode.

Budgetary Considerations

Administrative cost savings during the transition period would be minimal because of start up and phase out cost. However, in the long term, administrative and program savings should accrue.

Political/Social Considerations

Politically, pressure will be exerted from those organizations losing influence, power, or business, e.g., AHA, BCA, National Association of Blue Shield Plans (NABSP), etc. Beneficiary concerns will increase as patterns of communication between them and the current contractor are altered. If disruption occurs in claims processing during start up and phase out it could cause widespread beneficiary and congressional inquiry similar to that experienced by the Social Security Administration (SSA) in the Supplemental Security Income (SSI) program.

Option 4: Acquire legislation which permits the Secretary to combine Part A and Part B under a single contract while conducting experiments to test the feasibility of such an arrangement

This option is proposed to maximize HCFA flexibility in contracting by proposing the legislative changes needed to combine program contractors along functional lines while conducting experiments to test operational models. This option is based on the assumption that similar Part A and Part B functions can be combined: claims processing function, beneficiary and provider service functions, etc. The unique function of Part A, provider reimbursement and audit, could be handled as a separate contract.

A change in legislation regarding the nomination process would be required and massive workload shifts are anticipated as the option is implemented. Concurrent with obtaining the legislative change, experiments would be conducted to test operational models. Depending on the outcome of these experiments, a decision would be made on combining Part A and B.

Advantages

It would provide the legislative framework for the actual implementation of a combined contractor arrangement on a national basis if the experiments showed such an arrangement to be successful.

Experimentation would provide an opportunity to study and test contractor configurations under various contract models. It would provide time and insight to the industry so they could respond to new contract modes. It would provide the opportunity to be compatible with longer term health care concepts which are still in the developmental stage, e.g., State rate setting. It would provide time to educate providers and beneficiaries to a combined contractor concept while testing several models, thereby minimizing future delays in implementation, and providing for a smooth transition.

Disadvantages

This option may produce a one-time hardship for beneficiaries in the affected service areas. The beneficiary would have to adjust to a new telephone number to call for inquiries, changes in carrier personnel, etc. The disruption to the physician during the implementation phase could cause him to no longer accept assignment, thus shifting costs to the beneficiary. Finally, a changeover in contractors might result in higher total costs to the program during the conversion period, loss of jobs for personnel in the former contractor's office, and a loss of continuity in program integrity cases.

Costs/Savings

No appreciable cost savings are anticipated with the experimental model approach.

Steps Required for Implementation

Identify and develop combined Part A and B models; test combined model(s); develop a legislative package necessary to permit combined Part A and B contracting.

Timetable

Model(s) identification and development	3/1/79
Begin implementation of several models	10/1/79
Legislative package development and passage	10/1/81

Feasibility

Legislative Considerations

The legislative base exists for experimental contracts under Section 222 of Public Law 92-603. For the long-term operational implementation of the model(s), selected legislation would be needed.

Administrative Considerations

Experimentation does not present undue administrative issues. If implemented on a national level, it would be a considerable administrative undertaking requiring: (1) an overall implementation strategy; (2) a methodology for assigning contractors to service areas; (3) a methodology to establish service areas; and (4) modified work statements, performance standards, etc.

Budgetary Considerations

Administrative cost savings during the experimental period would be very minimal.

Political/Social Considerations

Political pressure will be exerted by those organizations losing influence, power, or business. Beneficiary concerns will increase as traditional communication patterns change. If during start up and phase out, claims processing disruption occurs on a large scale basis, widespread beneficiary and congressional concern will materialize, as it did in the SSI program.

Option 5: Conduct studies and experiments to test the relative advantages of the combined Part A and Part B contract mode

This option is to study and experiment with the combined Part A and Part B contract, with no commitment to change legislation, or to implement the combined contract on a national basis. These experiments could be performed with new, qualified organizations who are presently not Medicare contractors.

Advantages

This option would provide an opportunity to study and test various contract models in parallel with program evolution with no commitment to any particular alternative--all options would be left completely open. It would provide opportunity to give the industry insight into possible future plans, so that the industry can be responsive when a final option is selected. It would provide the opportunity to concurrently develop long-range health care concepts and implementation mechanisms. It would provide the time and opportunity to refine and create program administrative systems for the combined Part A and B contractor. It would diminish disruption to the program, and reduce risk of implementing untested contract modes. It would provide an opportunity to accurately measure and project cost savings.

Disadvantages

It would delay implementation of necessary program changes. Experimentation does not guarantee smooth transition and conversion from the present contract mode.

Costs/Savings

This option would not offer immediate cost savings, but would enable the Secretary to test for potential savings under a combined Part A and B contract mode.

Steps Required for Implementation

Model(s) identification and design, including the use of various incentives; offer the model(s) to the contractor industry; select the contractor; and begin operations.

Timetable

Complete model(s) design	3/1/79
Offer model to industry	6/1/79
Begin operational phase	1/1/80

Feasibility

Legislative Considerations

Present 222 legislation is sufficient for some models, whereas H.R. 3 rulemaking may be needed as a basis for other model

variations. To implement on a national basis, major legislative changes are needed, e.g., nomination process.

Administrative Considerations

An administrative consideration is to provide enough lead time to insure adequate responses to an experimental approach by the industry.

Budgetary Considerations

With respect to budget considerations, no problem is anticipated under this approach.

Political/Social Considerations

The only political concern anticipated is where a territory is opened up for competition, or where the industry anticipated this is not an experimental model, but rather the beginning of an operation regarding reconfiguration.

CONTRACTOR SELECTION PROCESS - PART B

I. Statement of the Issue

Should the current method of selecting carriers under Part B be changed? If so, should the number of carriers be reduced and should carrier contracts be awarded on a competitive basis?

II. Discussion of the Issue

The question has been raised as to whether or not the Medicare Bureau is satisfied with the present carrier configuration in the administration of the Part B Medicare program. There are benefits accruing from the current carrier configuration which enables carriers to establish and maintain working relationships with local medical communities and offer personal and immediate consideration to the beneficiary population. However, it can be demonstrated that a reduction could be achieved in overall administrative cost by reducing the number of carriers, assuring that the workload of each is sufficient to achieve the economies of scale demonstrated by the larger Medicare carriers, and still maintain a high level of service to the beneficiary and professional communities. A second consideration is whether additional savings to the program could be achieved by revising the carrier selection process to provide for competitive bidding in the awarding of fixed price or fixed rate contracts on a wider scale than is provided under the current legislative restrictions.

(Another concept which will not be explored in this paper is the utilization of regional centers for Medicare claims processing. A study of the feasibility of establishing regional EDP centers was conducted by Systems Architects, Inc., (SAI) for HEW under Contract No. 600-76-0111, titled, Medicare Regional Processing Feasibility Study, dated October 31, 1977.)

A. Background of Carrier Geographic Configuration

At the time the Social Security Act Amendments of 1965 were passed, it was the intent of Congress, as expressed in committee reports, that a sufficient number of carriers would be selected on a regional or geographic basis to promote a competitive performance environment and permit comparative analysis of individual performance. Carrier selections were based on their experience in health care reimbursement and on their financial stability. At the present time, there are 46 Medicare carriers administering 60 geographical areas.

B. Cost Reimbursement Contracts/Experimental Contracts

Generally, the Secretary is authorized to enter into contracts with private organizations without regard to provisions of the law relating to competitive bidding. The Act required the Secretary to enter into cost reimbursement type contracts with the carriers which result in neither profit or loss to the carriers in the performance of their contractual functions. At present, 44 carriers have cost reimbursement contracts.

In 1972, the Act was further amended to give the Secretary the authority to enter into incentive contracts with the carriers on an experimental basis. Three carriers now have incentive contracts (e.g. fixed price or fixed rate contracts). A fixed price contract sets a single fee to perform all carrier services for an area for the period of the contract regardless of the volume of claims processed, while a fixed rate contract sets a negotiated rate for each claim processed. In both types of incentive contracts, the carrier absorbs any losses or retains any profits.

The first incentive contract was awarded to Maryland Blue Shield for calendar year 1977 at a negotiated fixed rate. A second incentive contract was awarded to Massachusetts Blue Shield on a fixed price basis to administer the Medicare Part B program in the State of Maine from December 1, 1977 through September 30, 1980. More recently, a third experimental incentive contract was awarded to Electronic Data Systems Federal on a fixed price basis to administer the Medicare Part B program in Illinois. Implementation began July 1, 1978, and the operational phase will be from July 1, 1979, through September 30, 1983. The contract consolidates the current two-carrier jurisdiction into one.

Another Request for Proposal (RFP) on a competitive fixed price basis has been issued which will consolidate three carrier jurisdictions into one in upstate New York. The awarding of the Illinois and New York contracts will reduce the present number of carriers to 43.

Selections of carriers under the fixed price or fixed rate contracting process will not be limited to insuring organizations or to organizations currently serving as Medicare carriers.

In order to maintain quality of claims processing under competitive fixed price contracting, the Medicare Bureau will continue to monitor carrier performance using every mechanism which now exists in the cost reimbursement environment including the contractor inspection and evaluation program (CIEP), the use

of the Quality Assurance Program, and the application of statistical standards and criteria for evaluating compliance with the program requirements now under development. In addition, incentive contracts will continue to contain liquidated damage clauses which provide for the assessment of damages if the carrier's performance falls below specified standards. The Medicare Bureau is also conducting an evaluation of its fixed rate and fixed price contracting experiments to determine the strength and weaknesses of such arrangements.

C. Claims Workload and Administrative Cost

As a result of the present carrier geographic configuration, the claims workload is unevenly distributed. In fiscal year 1977, the range was from a high of 9,132,210 claims processed by California Blue Shield, which serves northern California at a unit cost of $2.53, to a low of 84,320 for Equitable of Wyoming with a unit cost of $4.32. The total Part B claims volume for fiscal year 1977 was 80,613,749 claims processed with a national mean of $2.98 per claim.

A further analysis of carrier administrative cost data arrayed by peer group (e.g., grouped by claims volume) indicates that for fiscal year 1977, 64 percent of the carriers in peer group I (claims volume averaging about six million claims) had unit costs at or below the national mean with an average unit cost of $2.64, while all of the carriers in peer group IV (claims volume averaging about 400,000 claims) exceeded the national mean with an average cost of $3.47. There is clear evidence that those carriers with a claims volume below 500,000 are at the highest end of the cost spectrum. However, once an optimal claims volume is achieved, there is no consistent evidence that further decreases in unit cost will occur in proportion to increases in volume.

D. Impact of Change of Carriers on Beneficiaries

Any change in Part B carriers will have some impact on the beneficiary population to varying degrees depending upon the option selected. About half (49.5%) of the 105 million requests for Medicare payment in CY 1977 were unassigned, e.g., submitted by beneficiaries to their local carriers. Since most carriers have been in the program since its inception, beneficiaries have become accustomed to submitting claims and securing program information from local carriers. In view of the fact that Medicare beneficiaries are elderly and ill, efforts must be made to assure that all changes in carriers are accomplished with as little confusion to them as possible, especially where periodic changeovers occur. Under the experimental contracts,

Medicare is developing the expertise to assure that Medicare beneficiaries are not adversely affected. The Bureau's experience in the Maine experiment indicates that beneficiary problems can be minimized by establishing an intensive public relations effort to educate beneficiaries to a change in the carriers. Early cooperation with Senior Citizen groups and Social Security Administration District Offices has been effective, as well as publication of the changes through direct mailings to beneficiaries and publicity in local media. Use of the same mailing address for submitting claims has minimized loss of claims.

Efforts must also be made to assure that any carrier turnover does not adversely effect assignment rates for the area since any reduction in the assignment rates will cause beneficiaries to assume a higher portion of their medical expenses.

III. Summary of Options

There are two subissues with respect to the carriers: reducing the number and the process for selection. In reducing the number of carriers the two options are to (1) establish one carrier per HEW region or (2) determine an optimum number based on workload statistics. With respect to the selection process, the two options are to (1) open all carrier areas to competition on a periodic basis or (2) open only selected areas to competition.

IV. Discussion of Individual Options

A. To reduce the number of carriers, two options are considered: (1) the establishment of one carrier per HEW region or (2) the reduction of the number of carriers to an optimum number based on workload statistics and other performance data.

Option 1: Reduction of number of carriers based on HEW regions

Advantages

Locating carriers in the 10 HEW regions should be simpler to administer and provide greater uniformity in the execution of policies and procedures. In addition, the Government should gain better control over EDP systems development and planning. Moreover, regional office staff could be utilized more effectively with less travel time and expense required for monitoring and evaluating carrier performance. Overall lower administrative costs should be achieved.

Disadvantages

The major disadvantage of this option would be the inequitable

distribution of workload by HEW region. For fiscal year 1977, the percent of total workload by region varied from 2 percent of the national total to 17 percent. Four regions accounted for 63 percent of the national workload and two regions each accounted for less than 3 percent. In addition, adoption of this option would severely limit the Secretary's ability to act if a carrier processing more than 10 percent of the workload were to withdraw from the program. For example, replacing a carrier processing over 17 million claims annually would be extremely difficult. This option could also have the effect of reducing competition among carriers since a smaller number of organizations would have the capability of processing the larger volume of claims. Implementation of this option would disrupt the entire Medicare program. All carriers, even those with optimal workload satisfactory performance and unit cost, would be affected and the impact would be felt by all beneficiaries. Furthermore, the distance between the regional carrier and the local medical communities would lessen effective communications between the carrier, the physician community, and the beneficiary population. With availability and personal contacts replaced by long-distance telephone communications, possible dissatisfaction with the program may significantly impact on an already dangerously low assignment rate.

Costs/Savings

Although cost savings are extremely difficult to project, the potential reduction in costs would be as much as $41 million if an average unit cost of $2.50 could be achieved. The $2.50 estimate assumes all contractors selected on competitive basis.

Timetable

Selection process--18 to 24 months

Implementation period--5 years (using staggered basis by region and State)

Feasibility

Legislative Considerations

Although no new legislation would be required if the selection of the 10 regional carriers is made under the present cost reimbursement environment, selection by fixed price or fixed rate competitive bidding would require the enactment of enabling legislation.

Administrative Considerations

By mandating large volume workloads, the program may be restricted to large organizations and the opportunity for small organizations to enter the field would be limited. Furthermore, if a contractor fails, there would be substantial program disruption while selecting another carrier for the entire region. If implementation of this option becomes infeasible, there would be considerable disruption and confusion in the administration of the Part B program.

Budgetary Considerations

Since the number of carriers would be reduced, the budget process would be simplified; however, the method of selection (cost reimbursement, fixed price or fixed rate) would influence the budget process.

Political/Social Considerations

Experience has shown that the removal of incumbent carriers and the selection of a new carrier often leads to political pressure and opposition on behalf of the incumbent. This most likely would occur in the reduction of carriers from 43 carriers to 10. It is certain that congressional concern would be expressed over the loss of the large number of lower level carrier jobs in existing areas as well as the potential disruption of service to beneficiaries. Socially, this option would have some effect on the beneficiary population which is accustomed to submitting claims to a local organization. Under this option, the entire beneficiary population would be affected rather than just those in selected areas. This disruption would have to be offset by retaining beneficiary services to some extent in local areas since the prime function of the program is to provide beneficiary services. All other functions should lead toward meeting this particular responsibility. Unless local contact is retained to resolve problems and errors, the regional carrier concept could not satisfactorily meet the needs of the beneficiary population.

Option 2: Reduction of number of carriers based on workload characteristics

The second option is revision of carrier configuration by reduction of geographic areas to an optimal number based on workload; e.g., about six million claims annually. Under this option, jurisdictions with large volumes would be retained and those jurisdictions with low volume would eventually be grouped into areas approximating the optimal claims volume. For example, a carrier jurisdiction may consist of one of the

following configurations, using fiscal year 1977 claims workload data:

- An entire State:

  Pennsylvania: 5.5 million claims
  Michigan: 5.3 million claims

- A sub-state jurisdiction:

  California: two areas with 9 million and 4 million claims respectively
  Florida: two areas with 5.8 million and 2 million claims respectively

- A multi-state jurisdiction:

  Delaware, D.C., Maryland, Virginia: 3.6 million claims
  Alabama, Tennessee, Kentucky, Mississippi: 5.5 million claims

Multi-state jurisdictions may be structured to offset the high cost of processing small statewide workloads against a larger volume.

Some smaller areas may also be retained where performance has been satisfactory as an entry into the program for smaller organizations who could not administer larger areas without first developing capabilities and acquiring experience in a small area.

Advantages

There should be an improvement in the efficiency of administering the program and greater uniformity in the application of Medicare policies and procedures, thus lower administrative costs. The workload could be allocated more equitably and fewer beneficiaries than in option one would be affected since the services of the existing large carriers who are performing satisfactorily would not be immediately interrupted. In addition, the Medicare Bureau would retain more flexibility in assigning carriers and would have the option of replacing a carrier (or reassigning a portion of workload) when one organization could not handle the workload.

Disadvantages

The most significant disadvantage would be some disruption of services to the beneficiaries in the selected areas. Longer distances may create some communications problems for sparsely

populated areas. As discussed in Option 1, there may be difficulty in maintaining effective professional relations with distant medical communities in those areas where several States would be combined to achieve the optimal workload.

Costs/Savings

Cost comparisons are difficult to make. However, if all carriers operated at the level of efficiency currently achieved by high volume carriers ($2.84), there could be a possible savings of $15 million. If selection by competition is assumed, a unit cost of $2.35 might be possible and this would result in potential savings of $59 million.

Timetable

Selection process--12 to 18 months

Implementation period--3 years (staggered by region)

Feasibility

Legislative Considerations

If elimination and selection of carriers is made in the present noncompetitive environment, no legislative action is required and the Medicare Bureau could proceed with implementation of the option. Flexibility of use of fixed price and fixed rate competitive contracts for all or part of the selection process as ongoing policy would require enabling legislation. (The selection process is discussed further under the second issue.) However, since the impact on the Medicare program would not be as great as under Option 1 (regional carrier concept), it is likely that congressional opposition would be minimized.

Administrative Considerations

Reduction of carriers to an optimal number would give the Medicare Bureau flexibility in determining the appropriate workload size to encourage participation of smaller organizations and also the flexibility in removing carriers with unsatisfactory performance.

Budgetary Considerations

The budget process may be simplified with the reduction of carriers.

Political/Social Considerations

Some adjustments would have to be made in services to beneficiaries in affected areas, as well as in communications with the medical communities outside the respective carrier's area. Congressional concern would be expressed at the loss of a Medicare carrier in some areas, as well as the potential loss of jobs and what may be perceived as a lessening of beneficiary services in such areas. Nevertheless, this option has the greater potential of achieving a reduction of administrative costs with the least impact on services to beneficiaries and in continuing cooperation with the medical communities.

B. Carrier Selection Process

Once the decision on the revised configuration of carriers is made, the method of reassigning or selecting the carriers to administer the established carrier geographic areas must be determined. The goal is to achieve a greater degree of competition and thereby assure the lowest possible cost to the program. One option would be to open all areas to competition on a periodic basis; a second option would be to open selected areas to fixed price or fixed rate competitive bidding while retaining some of the present low cost carriers with satisfactory performance on a cost reimbursement basis.

Option 1: Periodic fixed price or fixed rate competition

This option would require the issuance of RFPs for the administration of the program in designated geographic areas for an established period of time. The contract should cover an operational period of 3 years in view of the lengthy RFP procedures and the complexities of transferring responsibilities from one carrier to another. A renewal clause may be included which would provide the option of extending the contract for an additional 2-year period beyond the original period.

Advantages

This option should provide the best means to achieve the lowest possible price as well as create an incentive for carriers to process claims efficiently in order to maximize profits. Since performance below established standards would result in the assessment of liquidated damages, carriers would have much stronger incentives to meet the standards. Fixed price and fixed rate contracts provide the best environment for competition. In addition, the Part B type contract for claims processing services is a volume oriented operation readily susceptible to fixed price or fixed rate bidding. Furthermore, the inherent

conflicts in the continuing incumbency cost contract environment, e.g., relations with physicians and provider communities, would be reduced. Finally, the term of contracts can be fixed and recompetition appropriately scheduled to avoid undue program disruption.

Disadvantages

A lack of stability could occur in the program with service areas open to bid on a periodic basis with possible change in contractors. Phase-in and phase-out problems which now occur on a one-time basis in selected areas would be more prevalent since each territory would represent a potential contractor turnover site. An incumbent carrier who is performing completely satisfactorily could be replaced through the competitive process, although it should have the best opportunity to become the successful bidder on recompetition of the respective territory. Bidders might be restricted to larger carriers which are in a position to take risks and absorb or write off losses. It may be argued that although non-Medicare policyholders could be advantaged to the extent of any gain, they could be placed in a position of underwriting Medicare administrative costs in the event of loss in performance of the contract. In addition, some nonprofit organizations may not have incentive to compete, and some may not be allowed by their charters or corporate policy to take large risks. The phase-in of a fewer number of carriers with the optimum workload would be delayed since to date the carrier community with the capability of competing for large volume workloads has not been established. The phase-in of fixed price or fixed rate competitive contracts must, therefore, be slow to encourage competition and allow for small organizations to enter the market and develop the potential for handling workloads in the six million range. Some public confusion may be created over the administration of the program. The experience of the Medicare Bureau in the transfer of jurisdiction has been that it may take a year after the new contractor begins to process claims before the beneficiary population and the medical community adjust to the effects of the transfer. The reason for this difficulty in transferring jurisdiction is that each carrier has unique systems and procedures to handle local conditions. Conversion from one system to a completely different system is a major problem to be overcome by the incoming carrier. The transfer problems could outweigh cost savings to the program.

Costs/Savings

It is difficult to project cost savings in view of the short time in which fixed price contracts have been used by the Bureau.

However, this approach would lower administrative costs in those low volume areas which would be combined under one fixed price incentive contract. Incumbent carriers would be forced to achieve lower administrative costs to remain competitive.

The estimated cost savings in the Maine experimental contract are 6 percent of the total administrative costs, and 27.5 percent in the Illinois experiment. Total administrative costs for Part B carriers for FY 77 was $323 million. A projected costs savings from 5 percent to 25 percent would indicate potential savings of from $1.6 million to $80 million.

Timeframe

Development of legislative package--1 month

Enactment of legislation into law--12 months

Identification of territories to be combined--3 months

Selection Process--initially 6 months and continuing

Phase in by State and Region--2 to 6 years

Feasibility

Legislative Considerations

At the present time, there has been limited experience with fixed price/fixed rate contracting but results have been encouraging and this method of contracting seems both feasible and desirable. In view of the impact of the total program, some legislative delays no doubt would be encountered.

Administrative Considerations

Additional standards would have to be developed for use in the incentive contracts, and stepped-up monitoring procedures developed in order to assure there is no reduction in meeting program requirements and to assess application of liquidated damages in the event the carrier's performance fell below contract standards.

Implementation of this option would necessitate a transitional period of several years during which selected cost reimbursement contracts would be continued until such time as final conversion to fixed price contracts is concluded. Any change in carrier configuration may have a disruptive effect on the Medicare beneficiary population and provisions must be made to minimize

this impact through effective public relations efforts. By utilizing a phase-in approach, the Medicare Bureau will allow the transition to occur slowly enough to give smaller organizations sufficient time to enter into the competitive bidding environment and develop the capability to handle larger workloads.

Budgetary Considerations

The budget process would be simplified since the bidder would have the responsibility for projecting workload and setting and meeting cost standards.

Political/Social Considerations

The discussion under the first option above (Periodic fixed price competition) would apply, with the major concerns being the potential for continuing turnover of carriers, the disruption of services to the beneficiaries, and delays in claims processing time. Another consideration is the impact on carrier personnel. If a contractor cannot assure employees that their jobs will last more than a few years and provide opportunities for advancement, it may be difficult for Medicare carriers to attract and retain high caliber employees. As many experienced people face the loss of jobs with the loss of a contract, increasing congressional concern will be expressed over this issue. We would stipulate in RFPs that successful offerors would make valid attempts to hire displaced employees. In addition, we would expect some incumbents to succeed themselves.

Option 2: Combination of incentive contracts and cost reimbursement contracts

The second option would be to reduce the number of carriers in selected areas by employing a combination of competitive fixed price or fixed rate contracting and cost reimbursement contracts to permit a more orderly transition and assessment of a final decision on whether all carriers should be selected on a competitive fixed price or fixed rate basis. Present territories experiencing low administrative costs and satisfactory performance would be retained on a cost reimbursement basis. Areas which present improvement opportunities, particularly where related to low volume, would be competed with the use of competitive fixed price contracts. Such contracts would be for a 3-year period with options to renew for a 2-year period.

Advantages

Less disruption of the program would be expected under this option since satisfactory performers with low unit cost would

be retained on a cost reimbursement basis. In addition, this option could create an incentive for contractors to meet and exceed performance standards since those with cost reimbursement contracts would wish to keep costs low and performance satisfactory in order to retain such contracts, while those with fixed price contracts would wish to maximize profits and maintain performance standards in order to avoid the assessment of liquidated damages. Some lower volume areas would be retained to encourage participation by new contractors and serve as an environment for the development of capability to compete for larger areas. The reduction in the number of carriers where improvement opportunities are available would improve the level of services in certain areas, and the retention of satisfactorily performing carriers would not subject that area to the problems inherent in transfer of jurisdiction. Adoption of this option would give the Bureau the opportunity to continue to evaluate the effectiveness of current fixed price experimental contracts and use them to the best advantage.

Disadvantages

As discussed above, there would be some problems in communications between carriers and beneficiaries and some disruption in services to beneficiaries. In those areas where several States would be combined because of low volume, there would be a loss of personal contact with the medical community. Furthermore, specific policy would be required to delineate when an area would be competed to prevent controversy and charges of bias in the selection process. Because both cost reimbursement and fixed price contracts would be administered there would need to be two different systems for administration.

Costs/Savings

Although, as previously discussed, it is difficult to project cost savings, the Illinois contract demonstrates the potential savings possible from competitive bidding. Under the cost reimbursement approach, a 21 million claims volume over a 3-year period processed at $3.30 would have resulted in administrative costs of over $69 million, while the successful bidder received the contract on a bid of $41,800,000. One of the unsuccessful incumbent carriers, which had operated substantially above the national mean in unit cost, reduced its projected unit cost by about $1 per claim. Obviously, incumbent carriers with cost reimbursement contracts would be forced to lower administrative costs to remain in the program. A reduction of 15 percent of the FY 77 total administrative costs would result in a savings of $48 million.

Timeframe

Development of legislation--1 month

Enactment of legislation into law--12 months

RFP development and selection process--12 to 15 months

Implementation--3 years (staggered by region)

Feasibility

Legislative Considerations

This option would require a revision of the law to enable the Secretary to enter into fixed price contracts on a continuing basis when such arrangements would improve administration of the program.

Administrative Considerations

This option would require some increase in contracting staff, as well as in regional office and central office staff, concerned with monitoring of performance since the close monitoring and evaluation of performance will be necessary. The development of additional criteria to measure performance under fixed price contracts will also be necessary.

Budgetary Considerations

The budget process would combine the present requirements for cost reimbursement contracts and the process for those areas with fixed price contracts. This may increase the complexity of the budgetary process.

Political/Social Considerations

There will be some impact on the beneficiary population and the medical community in selected areas. There will also be the loss of some jobs in communities where a present carrier is not renewed. While there may be some congressional concern about the protection of existing carrier representation in their States, this option will be the least objectionable politically since fewer areas will be affected and some larger States where carriers are performing satisfactorily will be retained in the program. The greatest impact will be felt in the sparsely populated western States which would be administered by one carrier serving several such States.

NOMINATION PROCESS - PART A

I. Statement of the Issue

Should the method for selecting intermediaries under Part A be changed; should the nomination process be eliminated?

II. Discussion of the Issue

The procedure whereby provider groups or associations nominate the organization or agency that will serve as their fiscal intermediary under Part A has been in effect since the beginning of the Medicare program. Under this procedure, the Secretary may enter into an agreement with the nominated organization or agency if it is consistent with the effective and efficient administration of the program and the organization or agency is willing and able to carry out the required functions. Providers who are not members of a group or association or not desiring to deal with the intermediary nominated by their group or association may elect to deal with another available intermediary or be reimbursed directly by the Federal Government.

There is a growing feeling that the Medicare program could be more efficiently and effectively administered if the number of fiscal intermediaries were reduced. In pursuit of this objective, options apart from the nomination process are being considered as a basis for establishing intermediary-provider relationships under the hospital insurance program. A measure which will enhance this effort was provided in Public Law 95-142 which grants the Secretary authority to overturn the nomination process when it would improve the effectiveness and efficiency of administering the Medicare program.

A. Background

Section 1816 of the Social Security Act provides that groups or associations of providers may nominate a national, State, or other public or private agency or organization to serve as their Medicare fiscal intermediary. Provision was also made under Section 1815 for providers to receive reimbursement direct from the Federal Government if they so elected.

As a result of the nomination process, the Blue Cross Association (BCA) in Chicago was selected as fiscal intermediary by the bulk of the hospitals and by substantial numbers of skilled nursing facilities (SNFs) and home health agencies (HHAs) seeking participation in the program. Those providers nominating BCA were originally serviced by 75 Blue Cross Plans

under a subcontract with BCA. The number of subcontracting Blue Cross Plans has now been reduced to 68. The remaining provider groups and individual providers were originally serviced by commercial insurance companies or by the Government through the Division of Direct Reimbursement (DDR). The number of commercial insurance companies has since been reduced to eight.

As of March 1978, BCA was contractually responsible for servicing approximately 90 percent of the hospitals (6200), slightly less than 50 percent of SNFs (2300), and 80 percent of the HHAs (1900). Commercial insurance companies were servicing slightly less than 10 percent of the hospitals (700), 50 percent of the SNFs (2400), and 10 percent of the HHAs (200). DDR services 240 hospitals, 100 SNFs, and 360 HHAs. In addition, DDR makes payments to 400 Federal hospitals for emergency services.

Fiscal intermediaries were paid nearly $47 million in administrative costs during the quarter January-March 1978 and a similar amount in the preceding quarter. The following comparative statistics for the 6 months period October 1, 1977 to March 31, 1978, by peer groups of Blue Cross Plans gives a further indication of the cost of processing a claim:

October 1, 1977 to March 31, 1978

	Over 300,000 bills	150,000-300,000	70,000-150,000	Below 70,000
Avg. adjusted unit costs	$4.09	$3.99	$3.97	$4.35
Total bills processed	7.5 mil.	4.5 mil.	2.2 mil.	700,000
No. of Plans in each group	13	22	19	15

Similar statistics on Blue Cross Plans for a full year extending from October 1, 1976 - September 30, 1977, show the following:

October 1, 1976 to September 30, 1977

	Over 585,000 bills	288,000-585,000	164,000-288,000	Under 164,000
Avg. adjusted unit costs	$4.45	$4.36	$4.35	$4.66
Total bills processed	15.4 mil.	6.8 mil.	4.8 mil.	1.5 mil.
No. of Plans in each group	15	18	21	18

These statistics show that Blue Cross Plans handling workloads in a medium range in the upper chart 70,000-300,000 semiannually and in the lower chart 164,000-585,000 annually had the lowest average unit costs. Statistics on commercial intermediaries are not included above because of the unusual mix of providers they service which tend to distort average cost figures.

B. Legislative Changes Affecting the Nomination Process

Section 14 of Public Law 95-142 is the first major legislative change affecting the nomination process. Under this Section, the Secretary is given authority to assign or reassign a provider to a fiscal intermediary and to designate a single regional or national intermediary to service a class of providers. When exercising his authority to assign or reassign a provider, the Secretary is required to take into consideration the provider's preference of fiscal intermediary which has been expressed through the nomination process. The provider's preference may, however, be overturned by the Secretary if the change would improve the effectiveness and efficiency in administering this part of the Medicare program. Adversely affected intermediaries will be given an opportunity to appeal the Secretary's decisions through a hearing and judicial review before they are finally implemented. This legislative change addresses the issue of multiple intermediaries serving in a given area and was prompted in part by the problems inherent in trying to exercise adequate administrative control over a particular class of provider such as an HHA, when there are only a few in a particular area serviced by different intermediaries with little experience in their private lines of business and too few in Medicare to provide an adequate basis of experience.

C. Continued Applicability of the Nomination Process

The nomination process served a useful purpose in the timely implementation of the Medicare program. Providers were afforded an opportunity to actively participate in the implementation of the Medicare program through the nomination process. However, there are indications that the nomination process has in some instances linked fiscal intermediaries to groups of providers and individual providers that may not have resulted in efficient and effective administration. Moreover, the nomination process has only limited application now that participating providers are tied into their servicing intermediaries. New providers entering the program and providers requesting a change of intermediary are, for the most part, the only situations in which the nomination process continues to apply. Even in these decisions, the Secretary is legally bound to honor provider's preference only to the extent it is consistent with the effective and efficient administration of the program.

It is, therefore, felt that in the current climate of new initiatives to improve the efficiency and effectiveness of the administration of the Medicare program, a more responsive basis should be explored for relating providers to their servicing intermediaries.

D. Effect of Change on Medicare Beneficiaries

The options to be discussed deal primarily with changing the configuration of providers with their servicing intermediaries. Unlike the Part B program, there are few occasions under the Part A program for the beneficiary to contact the Medicare fiscal agent. The provider agreement requires that providers will not charge any individual for items and services covered by the Medicare program. Health care providers, accordingly, bill intermediaries directly for items and services provided Medicare beneficiaries, except for coinsurance and deductible amounts. These amounts are billed to the beneficiary by the provider. In those few instances where a contact may be required between the beneficiary and intermediary, the contact would likely be initiated by the intermediary. The intermediary correspondence would contain all the necessary identifying information including the intermediary address which should minimize any confusion on the part of the aged beneficiary in responding. Any change of intermediary should, therefore, have little effect on the beneficiary population.

III. Summary of Options

Four options will be considered as possible bases for reassigning providers:

- geographical area,
- class or type of provider,
- workload characteristics,
- a combination of the above.

Under these options, subdivisions of the broader topics will be discussed giving what are viewed as possible advantages and disadvantages of the approach; any source from which cost savings could be expected as a result of using the approach; the estimated timetable and steps in implementation; and the feasibility of adopting the option.

IV. Discussion of Individual Options

Option 1: Geography

A. National Intermediary

Advantages

This would be the ultimate achievement of the goal to reduce the number of intermediaries. An advantage of having a single national intermediary would be the greatly increased potential for consistent application of program policies and procedures. The single intermediary would have ample opportunity to gain expertise and a broad base of experience in servicing providers. A single system could be used for processing bills and possibly an extensive systems network employed. Monitoring a single intermediary operation on a national and regional level would improve the Medicare Bureau's ability to detect operational deficiencies and bring about corrective action.

Disadvantages

Reducing the present intermediary configuration to a single national intermediary would be disruptive to the present program operation. Massive technological changes of automated operations would be required. Poor performance by a national intermediary could have disastrous effects. A national intermediary to be effective for all aspects of the program would have to develop an operational capability of almost inconceivable proportions. The wide distribution of providers, unless served on a localized basis by a national intermediary, would impede efficient and effective program administration. Communications with individual providers would tend to be ineffective. Claims processing would most likely be slowed because of the distance of providers from the processing point, and the audit of providers might pose a complex and expensive situation.

The use of a national intermediary from the private sector would give the appearance of the Government promoting a monopolistic situation. This would bring a predictable outcry from the provider community and professional groups and probably even from the public. Appeals by adversely affected intermediaries would most likely continue interminably and implementation would accordingly be delayed.

Costs/Savings

When fully implemented, administrative costs should be reduced

considerably because the program would be maintaining only one intermediary operation.

Timetable

Implementation of the following steps would take approximately 5 years.

- Determine whether a national intermediary would fit within present legislative provision and, if not, prepare a legislative revision.
- Select a national intermediary.
- Handle intermediary appeals.
- Conduct a major phase out of other intermediary operations and a transfer of functions.

Feasibility

Legislative Considerations

This option runs counter to the nomination process and may not be compatible with Public Law 95-142 which could mean that revised legislation may be needed. If a single contract were awarded in the private sector, it might also be challenged under antitrust laws.

Administrative Considerations

Consideration might be given to the use of a single national intermediary for administering a very specialized provision of the law or for dealing with a select group of providers. If implemented on a national scale, a very gradual transition to full implementation would be necessary to ensure program continuity.

Budgetary Considerations

The budgetary process would be simplified under a single contract. Consideration should be given to the large number of systems and other technological changes that would be required. There would be major one-time nonrecurring costs to implement the change and terminate existing contractors.

Political and Social Considerations

Present intermediaries would have to scale down their operations

at considerable financial loss because of loss of contracts. The potential for provider dissatisfaction would probably be increased because of remote administration. Political pressure would probably be overwhelming for a configuration involving additional intermediaries.

B. Regional Intermediaries

Advantages

The use of regional intermediaries would result in substantially reducing the number of contractors administering the hospital insurance program. With the reduced number of intermediaries, there should be more uniform and consistent application of program policies and procedures. The assigned intermediaries would have the potential for becoming expert in the handling of problems occurring in their region and should individually be able to develop a comprehensive data base for cost reimbursement and monitoring activities. The monitoring of regional intermediaries by the Medicare Bureau should be greatly enhanced, especially if aligned with the Medicare regional offices. Start-up costs should also not be a significant budget item to the extent that presently participating intermediaries are used.

Disadvantages

If regional configurations are along the Medicare Bureau regional lines, this would result in an uneven distribution of the workload among the 10 intermediaries. Where there are large concentrations of the beneficiary population, the size of the regional intermediary operations may be unwieldy in size. Poor performance by a regional intermediary would affect a large number of providers with a potential for serious consequences depending on the extent of the deficient performance. The drastic reduction in the number of intermediaries may require interruptions of a large number of technological ties between intermediaries and providers and reestablishment of the ties with the new intermediaries at considerable cost to the program. Extensive systems changes may also be necessary. Conducting provider relations and provider audits could also pose major problems because of the large areas to be covered by the intermediaries. The greater service area would also tend to have an adverse effect on the timeliness of the claims process, particularly where bill and payment information is exchanged by mail.

A reduction of this magnitude in the number of intermediaries would present major phase-out and phase-in problems which might have a disruptive effect in some regions. Strong

objections can be expected from the provider community and a large number of appeals from adversely affected intermediaries.

Costs/Savings

Administrative cost savings can be expected from the reduced number of intermediary operations to be maintained. Benefit payments may also be reduced through the more uniform application of program policies and procedures.

Timetable

Implementation of the following steps would take 3-5 years depending on the technological and systems changes required.

- Selection of regional intermediaries
- Contract negotiations
- Phase-out of nonselected intermediaries
- Handling of appeals of adversely affected intermediaries

Feasibility

Legislative Considerations

A regional intermediary configuration could be implemented under the provision of Public Law 95-142.

Administrative Considerations

While the regional configuration could be implemented nationwide, it would appear more appropriate for use with sparsely populated regions or a select group of providers. To ensure program continuity, a gradual phase-in of provider changes may be necessary.

Budgetary Considerations

The reduced number of intermediaries would result in fewer administrative budgets. Systems and technological changes would also probably have significant budget implications. One time nonrecurring costs to accommodate the necessary changes would be substantial.

Political and Social Considerations

Political pressure would almost certainly be forthcoming with the large number of contractor operations that will be

affected and the effect of the reassignment of providers. Providers distant from the regional intermediary would possibly suffer added inconvenience by reduced service. Economically, there would be losses of jobs as a result of the reduced number of intermediaries which would likely be expressed through all available avenues.

C. State Intermediaries

Advantages

A State intermediary configuration would represent the least change from the present system and would be roughly equivalent in the number of States to the Blue Cross system. The number of intermediaries would be reduced by one-third. This configuration would likely result in the smallest number of intermediary appeals because the least number of intermediaries would be adversely affected, assuming that presently operating intermediaries are selected. If currently participating intermediaries are assigned, start-up costs should be minimal and fewer adjustments would be required for workload changes. Poor performance by an intermediary would have a more localized impact than in a larger configuration and recovery prospects from poor performance would probably be brighter and more rapid.

The use of State intermediaries would provide an opportunity to terminate or nonrenew marginal and small intermediaries performing at a questionable level. State Medicare intermediaries offer the greatest possibility for alignment with Medicaid fiscal agents if efforts are pursued to combine the two programs. State intermediaries would cause least program disruption under intermediary-provider configuration based solely on geography. There would probably be fewer disturbances to technological ties between intermediaries and providers inasmuch as fewer intermediary operations will be eliminated.

Disadvantages

Since a State intermediary configuration would generate the least change of the three geographic options discussed, the scope of potential improvement in achieving more uniform application of program policies and procedures would be somewhat less. This configuration could also mean that for some States, the workload of a single intermediary may greatly increase since there are presently few States in which the total provider workload is not shared with other intermediaries.

Costs/Savings

There would likely be some reduction in administrative cost under a State intermediary configuration due to the reduced number of intermediary operations to be maintained. We estimate savings of from 5 to 10 percent of total administrative costs.

Timetable

Implementation of the following steps would take approximately 3 years:

- select State intermediaries,
- handle appeals by adversely affected intermediaries,
- combine intermediary operations by State and phase-out nonselected intermediaries,
- contract negotiations.

Feasibility

Legislative Considerations

A State intermediary configuration could be implemented under the provisions of Public Law 95-142.

Administrative Considerations

Since it involves the least change from the present system, it could probably be implemented with the least difficulty.

Budgetary Considerations

From a budget viewpoint, there would appear to be minimal impact. Start-up costs would be nominal. Opportunity for more effective financial, budget management activities would be enhanced.

Political and Social Considerations

There will be the normal objections from providers which are dissatisfied with their newly assigned intermediary, along with the objections and congressional inquiries relative to intermediaries losing contracts or providers being reassigned. An economic consideration would be the loss of jobs by the nonselected intermediaries.

Option 2: Class/Type of providers

A. Configurations by Major Class of Providers--Hospitals, SNFs, and HHAs

Advantages

Intermediaries specializing by class of provider will gain expertise in all aspects of servicing the respective classes of providers. Included in this expertise is the potential for more rigid and consistent application and enforcement of policies and procedures pertaining to the major classes of providers. For some intermediaries, minimal changes may be involved because they already serve large blocks of providers in the same class. Under this approach, intermediaries could concentrate on gathering a data base to be used in monitoring and cost settlement activities. Monitoring of intermediaries by Medicare Bureau regional offices could become more specialized, thus increased control could be maintained over the various classes of providers at the Medicare Bureau regional office level, as well as by the intermediary.

Disadvantages

Depending on the area serviced by an intermediary, specialization by class of provider has the potential for increasing the number of intermediaries; for example, if specialization were within individual States, there would be nearly twice the number of intermediaries presently participating. In some areas, there may be so few of a single class of providers to make it inefficient and unreasonable to specialize by class of provider. Assigning providers to other than their intermediary of preference will almost always raise provider objections. There will be adversely affected intermediaries who will appeal their workload loss or restructured workload resulting from this configuration. There will be increased complexity in program administration because of the mix of provider interrelationships. There are hospitals, SNFs, HHAs, etc., owned and operated by the same organization or political entity and have common management and support services. Some SNFs and HHAs are hospital based and share common resources and cost accounting systems. Beneficiaries receive services from all classes and problems of utilization review and control would be exacerbated.

Costs/Savings

There may be administrative cost savings if a plan is devised for structuring intermediary service areas so that the number

of intermediary operations are significantly reduced. Benefit payment savings are likely to be a result of the specialized handling of coverage issues and closer surveillance of the various classes of providers.

Timetable

Implementing the following steps will take 3-4 years:

- Determining the area of a class of providers that will be serviced by an intermediary will vary for the different classes of providers because of the disparity in the number among the classes of providers in various areas.
- Selection of intermediaries
- Handling of adversely affected intermediary appeals
- Contract negotiation
- Phase-out/phase-in intermediaries

Feasibility

Legislative Considerations

An intermediary configuration by class of providers is specifically provided under Public Law 95-142. Such a configuration would probably have to be phased in on a gradual basis to ensure program continuity. Initially, consideration might be given to using this configuration for select classes of providers.

Budgetary Considerations

The effect to which the budget process is affected will be determined by the manner in which areas are carved out to be serviced by a single intermediary. A further budgetary consideration would be the systems and technological changes that may be required.

Administrative Considerations

Implementation of this option would be complex because provider types are often interrelated, part of one corporation and, therefore, hard to separate for administration purposes. Also, intermediary staffing and processing would have to be modified

as the switch is made from serving several types of providers to serving just one type/class.

Political and Social Considerations

This type of restructuring may bring accusations of special treatment or prejudice from the various professional organizations associated with the various classes of providers. Providers may be reluctant to work with intermediaries they are assigned to.

B. Configuration by Type of Control, e.g., Proprietary, Government

Advantages

A configuration by type of control would provide a basis for isolating blocks of providers which are expensive to service or which require close surveillance. This will also provide a basis for servicing those providers that fall into unique categories such as Government operated providers. Intermediaries would be in a position to develop expertise in servicing providers operating under the various types of control. Under this approach, intermediaries would also be able to install specialized safeguards and controls and enforce program policy more rigidly. A specialized data base could also be produced and used for cost settlement purposes. There is the possibility that use of this approach may provide the incentive for some providers to be more careful of their utilization practices and cost as they are being scrutinized.

Disadvantages

Provider configurations by type of control would be a narrow category in some parts of the country; consequently, there might be a wide dispersion of providers to make up a reasonable sized workload for an intermediary. The wide dispersion would add to the difficulty of servicing the providers and conducting audit and provider related activities. Major changes in systems technology may be required depending on movement of providers among intermediaries. Depending on the service areas of an individual intermediary, this configuration may not reduce the number of intermediaries. Whenever this configuration is used for purposes of special surveillance, there are likely to be objections.

Costs/Savings

Benefit payment savings should be realized from the increased safeguards and controls over utilization. Administrative costs savings may be forfeited, however, if the program becomes too refined in administration by type of control.

Timetable

Implementation of these steps will take 3-5 years depending on the groupings established.

- Selection and grouping of providers by types of control to be serviced by a single intermediary
- Designation of servicing intermediaries
- Handling of intermediary appeals
- Contract negotiations
- Phase-out/phase-in of intermediaries

Feasibility

Legislative Considerations

This type of configuration could be implemented under Public Law 95-142.

Administrative Considerations

Administratively, this type of configuration would appear more appropriate for use on a limited basis such as for problem type providers falling within a certain type of control. This would also provide a basis for assigning Government operated providers to DDR. All of the potential disadvantages could generate administrative problems.

Budgetary Considerations

Technology and systems changes required would be a budgetary consideration. The number of budgets could conceivably be reduced if type of control is defined in a manner that is not unduly restrictive and intermediaries are assigned a wide area to make up an optimal workload.

Political and Social Considerations

Providers singled out by ownership/control who have established high cost patterns are likely to raise objections which might be registered through various avenues such as congressional delegations and professional organizations.

Option 3: Workload characteristics

A. Size of Workload

Advantages

Intermediaries would be assigned workloads that would enable them to operate at optimal efficiency and effectiveness based on program experience. This would mean that inefficient and marginal contractors could be terminated from further participation and larger intermediaries which have patterns of high costs would have their workloads reduced in an effort to attain optimal conditions. Start-up costs would be minimal to the extent that current intermediary operations are utilized.

Disadvantages

Efficiency seems to be associated with intermediaries handling medium size workloads, therefore, it is not clear whether this type of configuration would reduce the number of intermediaries. Moreover, the optimal workload may not be uniform nationally because of varying factors such as labor market conditions, cost of living, and levels of education. Once optimal conditions are determined, it may be difficult to justify a configuration based solely on optimal workload considerations, for example, where there are large numbers of Medicare beneficiaries within a small area. The difficulty and costs of implementation in some of these situations would have to be examined closely to see if they outweigh the program benefit to be derived.

On the other hand, intermediary service areas where there are relatively few Medicare beneficiaries may encompass large areas making provider relations and audit activities a problem for more distant providers.

Costs/Savings

Administrative cost savings should be increased under this configuration since the optimal workload is normally correlated with lowest cost situation.

Timetable

Implementation of these steps would take 3-5 years.

- Determination of optimal workload situation
- Determining surviving intermediaries and the feasibility of introducing new contractor operations
- Contract negotiations
- Handling of intermediary appeals
- Combining of workloads/reduction of workloads to attain optimal situation
- Phasing out contractor operations eliminated from the program

Feasibility

Legislative Considerations

This approach may be implemented under provisions of the current law.

Administrative Considerations

An administrative consideration would be the feasibility of reducing large intermediary operations and combining smaller workload.

Budgetary Considerations

From a budgetary viewpoint, it will have to be determined whether savings to be realized will outweigh the costs and administrative difficulties inherent in starting a new intermediary operation and combining workloads.

Political and Social Considerations

Objections will be registered by intermediaries having to scale down their operation as a result of workload loss. Intermediaries losing their contracts will undoubtedly express their dissatisfaction through every available channel. A social consideration would be the loss of employment where there are scaled-down operations or terminations of contracts.

B. Complexity of Workload

Advantages

Under this configuration, it is envisioned that provider workloads would be assigned according to the level of difficulty in processing them. The level of difficulty may be defined in a number of ways. The level of technology existing between an intermediary and provider would be a heavily influencing factor in making a determination of the workload complexity. For example, some provider bills are submitted by wire with edits already performed which would produce a higher degree of accuracy and, accordingly, increase the speed with which they can be processed. Providers capable of this type of transmission would interface with intermediaries capable of receiving these wires. The intermediaries may also be capable of screening the bills by computer. On the other hand, providers submitting bills requiring manual processing would be matched with those intermediaries operating at a lower technological level.

Using this approach has the potential for reducing administrative costs, and fully utilizing existing intermediary resources. Servicing intermediaries could become specialized in accordance with the relative complexity of cases they handle which may also improve the timeliness of processing more complex bills. Using this basis for configuration may reduce the number of cases in which telecommunication network interruptions may be required and/or systems changes made to accommodate a reassignment. This is true because a number of the intermediary-provider ties already established would survive under this configuration. Monitoring of intermediaries should be facilitated since program attention can focus on those provider bills where the accuracy rate is lower.

Disadvantages

Those intermediaries servicing providers submitting more complex bills may experience increased administrative costs because processing of less complex bills would no longer be an equalizing factor. Separating providers in terms of the complexity of the workload they submit may not always be a clearcut determination. Distinguishing between degrees of complexity may result in objections from intermediaries and providers. Timeliness in the claims process is a factor for evaluating intermediary performance, and it may be difficult to establish criteria that would be equitable for the various degrees of complexity. This type of configuration may be

unrealistic to be used on a nationwide basis because many providers' workloads could not be categorized in their entirety as falling into complex or simple bills.

Costs/Savings

There may be savings in administrative costs particularly where bill processing is reduced to little more than a check writing operation.

Timetable

Implementation would take 3-4 years.

- Identify categories of providers submitting workloads ranging from simple to complex
- Select intermediaries
- Handle adversely affected intermediary appeals
- Phase-in/phase-out intermediaries

Feasibility

Legislative Considerations

This configuration may be implemented under Public Law 95-142.

Administrative Considerations

An administrative consideration might be given to direct reimbursement for those providers or types of bills requiring minimal intermediary input in the claims process. This might be considered too for use among intermediaries and providers with sophisticated technological ties.

Budgetary Considerations

Intermediary budgets based on complexity of workload may be more difficult to process because of variations in productivity and costs caused by varying degrees of difficulty.

Political and Social Considerations

Since there may be questionable delineations in the degree of complexity of some provider cases, there are likely to be objections to this approach.

Note: The discussion of a configuration based on workload does not address that part of the intermediary workload that is generated by audit and cost settlement activities. An adequate measure has not been developed that gives weight to quality of the activities, as well as the number completed.

Option 4: Combination of geography, class/types of providers, and workload characteristics

Advantages

This approach would provide flexibility to the provider-intermediary configuration beyond what would be allowed using any of the three options singularly. The common denominator for all configurations would be an optimal workload situation. Geographically, areas could be carved out approximating the optimal workload situation that could be handled by an intermediary. Those classes or types of providers requiring special attention could be divided up by geographic areas also giving consideration to what would constitute an optimal workload situation for an intermediary in terms of size and complexity. Under this approach, marginal intermediary operations could be eliminated from the program. Administrative cost savings should be maximized because intermediaries will be servicing providers within a geographic area or a certain class or type of provider which represents an optimal workload situation. Benefit savings should also result from the expertise gained through more specialized configurations. Developing configurations using combinations of the three options would make fuller use of experience gained in operation of the Medicare program. This approach should enable the program to reduce the number of intermediaries to the most effective complement for operating the hospital insurance program under the present legislative provisions.

Disadvantages

A major challenge under the combined approach will be to determine what constitutes an optimal operating level and fit this into geographic areas that can be effectively serviced by an intermediary. Seemingly, the optimal level could vary for different parts of the country because of differences in labor markets and other factors. The optimal level may also vary according to the type of workload that is being handled.

Using the combined approach may result in some intermediary service areas being quite diverse, some following State lines, others including multiple States, while others may include parts of two or more States. This may be further diversified

if certain classes or types of providers are carved out to be serviced by separate intermediaries. This major restructuring has the potential for being disruptive. Therefore, for program continuity, it may be necessary to conduct a very gradual phase-in program. Since a number of intermediaries' operations will be affected by this approach, we would expect it to generate a number of intermediary appeals. Similarly, displaced providers may be expected to raise objections to being reassigned to other than their chosen intermediary.

Costs/Savings

Savings in administrative costs should be maximized since three cogent factors are considered in the intermediary selection. There should also be savings in benefit payments as intermediaries gain expertise in servicing classes or groups of providers.

Timetable

Implementation should take 4-5 years.

- Determine what represents an optimal workload situation
- Select intermediaries to be considered for servicing the various configurations
- Handle intermediary appeals
- Contract negotiations
- Phase-in and phase-out of intermediaries

Feasibility

Legislative Considerations

This option may be implemented under Public Law 95-142.

Administrative Considerations

An administrative consideration under this option, as well as other options that are considered, is how to dovetail the option with the application of the standards and criteria which are mandated by Public Law 95-142 for the selection of intermediaries.

Budgetary Considerations

The major restructuring of some intermediary operations may involve some large costs such as telecommunication and systems changes that would have to be weighed against the benefit to the program.

Political and Social Considerations

Considerations to be taken into account are the elimination of some contractors from program participation which may involve the scaling down of their operations and loss of jobs. Political pressure is likely to be felt resisting such change of this magnitude.

THE ROLE OF THE DIVISION OF DIRECT REIMBURSEMENT

I. Statement of the Issue

What role should the Division of Direct Reimbursement (DDR) continue to have in the present changing environment for improving the efficiency and effectiveness of administering the Medicare program?

II. Discussion of the Issue

DDR exists because the original Medicare law in Section 1815 of Title XVIII gave providers the right to deal directly with the Government rather than through an intermediary. The 1977 Amendments to the Social Security Act, Section 14 of Public Law 95-142, gave the Secretary authority to alter provider/intermediary relationships in the interest of program efficiency through the assignment or reassignment of providers. Thus, there is a need to look critically at the DDR operations. Does DDR need to exist? To what extent? For what purposes? For how long?

A. Background

DDR was established under the authority of Sections 1815(a) and 1874(a) of the Social Security Act. Section 1815(a) provides that "the Secretary shall periodically determine the amount which shall be paid to each provider with respect to the services furnished by it." Section 1874(a) provides that "the Secretary may perform any of his functions under this title directly, or by contract...." DDR was established under pressure brought to bear by large blocks of providers and individual providers, both public and private, desiring to deal direct with the Government rather than have to submit their bills to a third party payor. DDR, accordingly, was created in response to this pressure and in conformity with the statutory provision.

Section 14 of Public Law 95-142, which was enacted in October 1977, was the first legislative change with the potential for impacting directly on the role that DDR has served in the Medicare program although the experimental authority in Section 222 of Public Law 92-603 could also affect DDR.

B. Current Operation of DDR

As of June 30, 1978, DDR serviced the following complement of providers:

243	Hospitals (32 of which provide renal services)
410	Emergency providers (405 Federal and 5 nonfederal)
6	Chronic Renal Disease facilities
16	Migrant hospitals
32	Kaiser providers (2 of which provide renal services)
86	Skilled Nursing Facilities
17	Physical Therapy providers
384	Home Health Agencies
160	Comprehensive Health Centers
1354	TOTAL

These providers are located in 45 States, plus the District of Columbia and Puerto Rico. With the exception of Kaiser providers, DDR performs all the basic functions of an intermediary. This includes the review and processing of claims, establishing interim rates, settling cost reports along with related training and review activities. Performance data for the period October 1977 - March 1978 show that the cost per claim processed by DDR was $5.26 (including audit costs) compared to $5.54 (including audit costs) for all Blue Cross Plans and commercial intermediaries. Workload statistics for the month of June 1978 showed that DDR had 1.8 weeks work on hand compared to 1.0 weeks work on hand for all Blue Cross Plan and commercial intermediaries. Related statistics show that nearly 16 percent of bills submitted to DDR require additional development while only 5 percent of those submitted to contracting intermediaries required additional development. These statistics which show a high bill development rate and an adverse bill mix account for the excessive workload backlog in DDR.

During the period July 1, 1977 - June 30, 1978, DDR processed 1.6 million Part A bills and 786,000 Part B bills. Part A payments during that period totalled $447 million and Part B payments totalled $63 million. In the process of developing and refining their claims operation, DDR has applied automatic data processing technology extensively. Performance statistics along with a subjective evaluation of its operation shows that DDR has generally responded satisfactorily to its assigned responsibilities in the reimbursement of providers. This has

been accomplished in spite of the varied bill types which tend to place upward pressure on costs and the timely processing of bills.

In addition to the functions normally performed by an intermediary, DDR has been given responsibility or is being considered for projects which require special handling and/or attention. These responsibilities include:

- Reimbursement of comprehensive health centers.
- Participation in a test project for processing and reimbursing bills for Medicare and Medicaid in New York hospitals.
- The audit and reimbursement of Kaiser providers. The Kaiser Plan had performed the entire intermediary function for its providers until 1976 when it was determined that there was a potential conflict of interest and DDR was assigned the audit and reimbursement function.
- Consideration for the funding of End-Stage Renal Disease (ESRD) networks which are presently handled in a somewhat fragmentary manner due to the unique nature of the chronic renal disease program.
- Administration of the Migrant Labor Project under which claims are processed for medical services provided to migrant workers.
- Participation in the Triage Project in Connecticut, designed to provide a full range of health, social and support services.

DDR thus provides an experimental capability for the testing of proposed procedures and program modifications for the Medicare Bureau. It provides the Government with an immediately available resource for conducting experiments on making reimbursement for services not presently covered in the Medicare and Medicaid programs. Experience acquired through these experiments has been and will be of great value in making decisions about whether to cover medical and medically-related services not included in present health financing programs. The close availability of DDR staff -

with the skills in handling a wide variety of unique reimbursement programs - to those developing experimental protocols enables many experiments to be put in place with extremely short lead times. In the past, this has often proven to be extremely valuable in meeting Congressional concerns for prompt action in getting various demonstrations and experiments underway.

Notwithstanding DDR's convenience and satisfactory performance, there are disadvantages to maintaining DDR's operation as it now exists. To do so would continue the situation where unhappy or dissatisfied providers choose DDR as an alternative to a fiscal intermediary. Because of this DDR has an unusually large number of providers that tend to be difficult to work with. DDR's operation is the only one serving providers on a national basis, with providers scattered throughout the country. A relatively large staff exists centrally and regionally to handle this workload. These factors necessarily cause inefficiency in the system.

III. Potential Role of DDR

There is considerable rationale and support for diminishing the present level of DDR activities. The hard decisions to be made concerning contractor reconfiguration, selection and reimbursement will have a major impact. However, any such decisions and their implementation should be carried out on a carefully planned, phased basis over an appropriate period of time.

As a first step in the scaling down process, we would propose to limit the availability of DDR to select providers as determined by the Medicare Bureau. This would include servicing discrete workloads being generated by unique providers or providers requiring special attention. Governmental providers on the Federal and possibly lower levels would continue to be serviced by DDR. Meanwhile, with the continuing implementation of Section 14 of Public Law 95-142, the number of DDR-serviced providers is likely to be reduced substantially as the assignment of classes of providers to contracting intermediaries is realized.

Under the proposed approach, providers being serviced by DDR over the long run would be only governmentals on the Federal and possibly some lower levels. If our long-range objective of moving to fixed price contracting is accomplished, DDR's

operation will naturally diminish as providers they now service are included in geographic areas put up for bid.

Aside from serving governmental institutions, DDR's remaining function would be to handle experimental projects and activities as the need arises.

SEPARATE CONTRACTING FOR
PROVIDER REIMBURSEMENT AND AUDIT FUNCTION

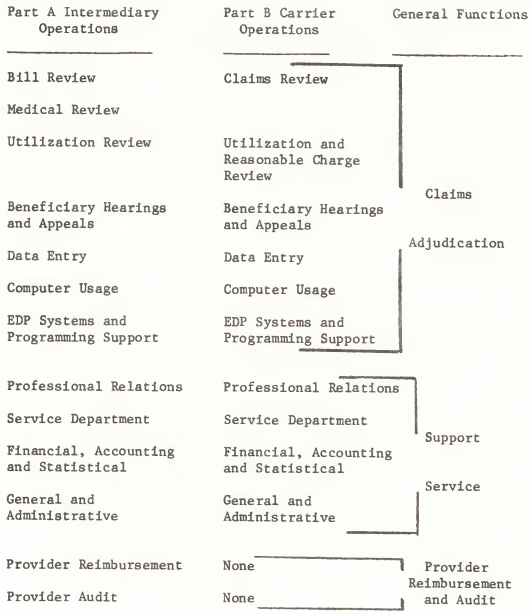
I. Statement of the Issue

Should Medicare, when combining Part A and B workloads, have a contractor perform the complete range of present functions (claims processing and support services, as well as provider reimbursement and audit), or should the combined Part A and B contractor perform only selected functions, e.g., claims processing and support services combined with the provider reimbursement and audit functions contracted for separately?

II. Discussion of the Issue

The objective of this paper is to describe how the functions are presently handled, how they might be handled, and identify the advantages and disadvantages of such a change. Even though the discussion is based on the combined Part A and B contract, the concept of contracting for the provider reimbursement and audit function separately could be applied to present intermediary contracting.

To establish the framework for the discussion of a different functional arrangement with contractors, the general individual operations are listed, and their similarities and differences between the Part A and Part B contractors discussed. Using the same functional format as the Medicare Final Administrative Cost Proposals, the following table illustrates how the operations can be grouped into three general functions: (1) claims adjudication; (2) support services; and (3) provider reimbursement and audit. The comparison of operations is as follows:


Part A Intermediary Operations
Part B Carrier Operations
General Functions
Bill Review
Claims Review
Medical Review
Utilization Review
Utilization and Reasonable Charge Review
Claims
Beneficiary Hearings and Appeals
Beneficiary Hearings and Appeals
Adjudication
Data Entry
Data Entry
Computer Usage
Computer Usage
EDP Systems and Programming Support
EDP Systems and Programming Support
Professional Relations
Professional Relations
Service Department
Service Department
Support
Financial, Accounting and Statistical
Financial, Accounting and Statistical
Service
General and Administrative
General and Administrative
Provider Reimbursement
None
Provider Reimbursement and Audit
Provider Audit
None

At the present time, there are many similarities between the operations performed by intermediaries and carriers in the handling of claims. Bills are received, reviewed, and paid. Denied bills are subject to hearings and appeals. Bill processing relies heavily on the use of computer operations and facilities. Even though the operations are similar, the individual procedure for processing an intermediary bill is different from the individual procedure for a carrier claim. In many cases, individual procedures are due to Part A and Part B program differences. For example, in the claims review area, intermediaries emphasize admission notice processing, whereas carriers do not receive admission notices. Notwithstanding the procedural differences, the intermediary performs similar operations in the adjudication of claims. In addition to claims adjudication process, intermediaries and carriers have similar "support" or "overhead" activities, e.g., professional relations, service department, financial and accounting, etc. Such activities as personnel, storeroom, printing, mailroom, and record keeping are similar in both Part A and Part B contractors, and in some companies are allocated between Medicare Part A and Part B. With the present similarities in intermediary and carrier operations for claims adjudication and support services, Health Care Financing Administration (HCFA) could merge the workloads of Part A and B and let a single contract for these functions. Basically, the functions are conceptually compatible, but many procedural adjustments would be needed.

The function of provider reimbursement and audit is unique to the intermediary. The need for the function is related to the basic program design--physicians are serviced by carriers, and are reimbursed on a prospectively determined rate basis, whereas hospitals, skilled nursing facilities (SNFs) and home health agencies (HHAs) are serviced by intermediaries, and are reimbursed on a retrospective cost basis. With carriers, the final reimbursement is accomplished during claims processing. With intermediaries, the final provider reimbursement is determined after the year is ended, and is based on a provider cost report submission, review and settlement.

The provider reimbursement and audit activity is extremely important since it determines the reasonableness of cost for service related to patient care. In fiscal year 1977 $44 million in administrative cost for audit and reimbursement were incurred in the determination of $16 billion in program payments.

Provider reimbursement includes activities related to: (1) establishing, reviewing, and revising interim reimbursement rates, including periodic interim payments; (2) overpayment recoupment; (3) consulting services to providers for the purpose of establishing and maintaining provider accounting systems.

Provider audit includes activities related to the in-house or subcontract activity for desk review, field audit, report writing, and settlement, as well as appeals, as they relate to settlement. In the concept of a combined Part A and Part B contractor, a single contractor would be responsible for all contractor activities related to provider reimbursement and audit.

III. Option for Consideration

The basic option is to experiment with separating the provider reimbursement and audit function from the other functions performed by the contractor, which is processing the Part A and Part B claims workloads. The provider reimbursement and audit function would be let under a separate experimental contract to a successful offeror. The claims adjudication and support service functions for Part A and Part B workloads would also be under a separate contract. The company with the claims processing contract could also be awarded the experimental provider reimbursement and audit contract; however, there is no compelling reason why the two contracts would have to be with the same company. In fact, it is envisioned that accounting-type companies could perform the provider reimbursement and audit, and the more traditional intermediary- and carrier-type companies could end up processing claims, etc. Thus, the experimental contract for the provider reimbursement and audit function could be with a company that is independent of the claims processing and support services contractor. In addition to testing the concept of separation of functions, the contract for provider reimbursement and audit functions would also test the type of reimbursement; namely, cost, fixed price, or fixed rate bases. This functional variation is an entirely new administrative arrangement.

Accordingly, there are several technical aspects about which information is needed:

- The optimum number of providers a company can effectively service. Should the company handle special classes of providers; should it handle all providers within a geographic area; and should the contract cross State boundaries?

- The appropriate length of a contract. Should it be for 3 years, 5 years, or some other combination?

- The level of specificity required in the company's work statement. Will the contract specify the number of desk reviews and audits, as well as the particular type desk review and audit program to be used.

- The intensity and frequency of desk reviews and audit. Will and should they increase?

- The selection process and evaluation of offeror's proposals need to be determined.

- The performance methodology for contractor evaluation. Should it be quantitative, rather than non-quantitative? Should it be process or end-product oriented?

Another part of the learning experience is whether contractor replacement will result in the loss of valuable trained accounting staff. Some people contend that contractor replacement will cause the contractor to be less knowledgeable of the provider's services. Thus, they will not know where to direct audit efforts. Another school of thought contends that accounting staffs are constantly turning over and all that is needed when replacing a company is a few well-trained, core staff accountants and managers, who can be obtained in the labor market.

An integral part of the discussion on this option is the legislative base. If this option were adopted on a national level, Section 1816 of the Act would have to be changed since we would be changing the nomination process, as well as the definition and functions of an intermediary. While the legislative changes are being developed and enacted, this option could be implemented on an experimental basis, using the authority in Section 222, Pulbic Law 92-603.

A. Advantages

The separation of the claims processing and support services functions from the provider reimbursement and audit function would have the following advantages:

- Depending on the selected company, separate contracts reduce conflict of interest by creating a check and balance system through the use of two companies; or separate contractual accountability could exist within the same company.

- Economies of scale would be promoted by permitting companies to specialize in claims processing and support services, and not be hindered by the provider reimbursement and audit function.

- Separate contract responsibility would exist for the most important intermediary function that controls the amount of program payments.

- Either of the separate contracts could be terminated with less impact on the other function(s).

- A base for integration of Medicare and Medicaid would be provided since the common audit function could be established without the complexities of handling the claims adjudication and other support services.

- Future program changes, such as prospective rate reimbursement, State rate setters, etc., could more easily be adopted.

- The provider reimbursement and audit function could be offered to an expanded market heretofore used only on a subcontract basis, e.g., the independent accounting firms.

B. Disadvantages

- The Social Security Act would have to be amended, which could adversely affect the providers and intermediaries. The affected organizations will bring political pressure and possible lawsuit in order to maintain the status quo.

- Depending on the selected companies, the separation of functions could increase the total number of contractors, and make administration by HCFA more difficult.

- It may break the traditional relationships which have been established between intermediaries and providers, even in their private lines of business.

- Smooth operations could be impeded because of communication links that are needed between the two possible separate functional contractors.

- A shift in emphasis to reimbursement and audit function will require changes in monitoring and evaluation procedures and HCFA staff expertise.

- If the Title XIX functions are merged into a single provider reimbursement and audit contract, then the issue of State or Federal control of program payments must be considered.

IV. Conclusion

Experiments could be conducted with a separation of the reimbursement and audit function from the claims processing function. The experiments would be directed toward providing the Bureau with more administrative experience in this functional arrangement. Among the specific areas to be addressed are: appropriate contractor workload, type of reimbursement (cost, fixed price, fixed rate, etc.), length of contract, specificity of work statement, selection process and evaluation of offerors, type of monitoring and performance standards, evaluation of offeror proposals, etc.

For the long term, HCFA should seek flexible legislation which enables the Bureau to use various contract forms and function configurations. This is also compatible with integrating Part A and Part B Medicare contracting and eventually integrating Medicare and Medicaid.

THE MOST COST EFFECTIVE BASIS FOR COMPENSATION OF CONTRACTORS

I. Statement of Issue

What is the most cost effective and feasible type of contract to be utilized in compensating contractors for performing functions of Titles XVIII and XIX operations?

II. Discussion of Issue

The primary objectives that should be met through any contract between the Government and industry include:

- accountability - financial and technical,
- responsibility - delivery and product oriented; fiscal agent and processing,
- corporate commitment - personnel; top management control; resources,
- cost control,
- delineation of scope of work, and
- innovation - flexibility in hardware; software; allowance for future changes.

There are several alternatives available to the Government for compensating contractors for work relative to Titles XVIII and XIX. Included in these alternatives are the following:

- cost reimbursement,
- cost reimbursement plus incentive,
- firm fixed price,
- fixed rate, and
- insuring agreements.

The various types of contracts evolved in response to a wide variety of contracting environments and requirements. These requirements ranged from very simple, redundant operations producing very specific material or service-oriented products, to extremely complex research and development efforts where projects could not be defined and technical uncertainties made cost estimating very risky.

The basic issue is what contracting procedures for performing bill processing functions under Titles XVIII and XIX insures the specified products and services, invites management and technical innovations, and allows firms with competence and capabilities to compete and participate at a reasonable profit.

Future contracting should also reflect the practical aspects of Government's and industry's respective roles. The Government's basic responsibility is to manage and administer the Titles XVIII and XIX programs with industry performing the claims processing activity. Also, there is increasing pressure on Government to establish controls and ceilings while at the same time expand the numbers of Government programs in the social, health and welfare areas. The contracting techniques used to accomplish these Government objectives should allow the Government accurate and specific management and monitoring techniques emphasizing products and deliverables, while allowing the contractor latitude in managing and controlling the contracted process with minimum interference. The Government should exercise control through penalties where products and services are poorly performed by the contractor.

The efficiencies of setting up and operating fixed resources (procedures, computer resources including software and hardware, trained personnel and geographical locations) must be balanced against the long range need for change due to new legislation, regulatory change, and the fast rate of change in applicable state-of-the-art technology. Therefore, the price for flexibility of organization (both Government and contractor) and ability for change in technology must be clearly understood.

By definition, cost contracts have little risk to the contractor and require the least specificity in definition of work at the time of contract award. They also minimize contractor resistance to change. However, cost contracts tend to lock the Government to specific industry contractors. In addition, the total cost of performing the work probably is greater than under other arrangements. Cost type contracts might lead to innovation, but only within the abilities of the locked-in configuration of resources and only if the Government prods by detailed management and monitoring. In a fixed type contract, the cost of the specific work is probably lower because of the specificity of the required work and the incentive to contractor to control and reduce costs. Innovation could be greater because of the pressure of minimizing cost by developing state-of-the-art clean and fast techniques. The advantage of fixed price contract over cost reimbursement contracts include:

- enabling more cost effective and productive response during the period of performance,

- allowing the Government to adhere to the role of administering and managing rather than accomplishing the work,
- allowing innovation derived from the varied minds of a broader base of industry,
- increasing the specificity of the scope of work,
- providing greater accountability on the part of the contractor, and
- establishing specific responsibility through the contract.

A. Cost Reimbursement

A cost reimbursement contract is defined as a method of reimbursing the contractor for all costs of performance determined to be allowable, reasonable and allocable to the contract as described in the agreement. The Department of Defense Procurement Training Handbook states that this type of contract should be used when "the estimate of cost is as reasonable as the circumstances permit but because of the magnitude of the uncertainties involved it is not adequate to support a mutually acceptable fixed-price arrangement."

Medicare contractors (with one major caveat) have been operating under a cost reimbursement for their administrative costs arrangement since the inception of the program. The principles followed are spelled out in the Federal Procurement Regulations and the contract with the Government. Medicare contractors are not at risk with respect to program benefit payments as these are entirely underwritten by the Federal Government.

The major caveat in regard to Medicare is that claims processing under Part B has utilized the services of sophisticated facilities management organizations to handle EDP operations; e.g., EDS, OSI, etc. These contracts are selected by competition engaged in by the carrier as required under its Medicare contract. At present about 30 percent of the 136 million Part B claims under Medicare are affected by facilities management competition.

Cost contracts, which generally do not include provision for a fee, are usually used for research and development with non-profit organizations. The Department of Defense follows a principle that this type of contract may be used only after a

formal determination that it is likely to be more cost-efficient than any other type, or that it is impractical to secure services of the kind or quality required in another manner. This type of contract is mandated for the Medicare program.

Advantages

1. Greater control by the Federal Government. The contractor's financial operations are closely monitored by regional and central office personnel. The contractor submits an annual budget request based on the number of claims to be processed. The approved budget becomes the spending plan for the period. Contractors are reimbursed for benefits paid and administrative expenditures through the checks paid basis under letter of credit procedures. Regional office staff and on-site personnel perform reviews to be assured the contractor is operating within prescribed standards. The HEW Audit Agency reviews the financial operation to determine that costs claimed by the contractor are reimbursable.

2. More flexibility to make program changes without opposition or decrease in performance. Since program changes stemming from legislation and/or policy revision are reimbursed by the Government, there is no necessity for lengthy negotiations with contractors on implementing the changes.

3. Less specificity needed in contract. Terms of the cost-reimbursement contract do not require precise definitions since changes for any reason can be instituted without modifying the contract. To avoid disputes and requests for contract changes, contracts which are of the fixed price type have to include definite performance specifications.

4. Minimal disruption to program. Experience in the Medicare program illustrates this advantage very forcefully. Contracts generally have been renewed without interruption in service. There have only been a few terminations and four or five carveouts because of poor performance and/or high unit cost in the years the Medicare program has been in existence. With the exception of Section 222 experimental contractors (three under contract and one under consideration), all Medicare contractors have operated under cost reimbursement

contracts. The small number of terminations, carve-outs and experiments under 222 out of a universe of about 124 contracts operating over a 13-year span, strongly suggest that use under Medicare of the cost-reimbursement contract provides considerable program stability.

5. Continuity of audit and reimbursement function. Medicare intermediaries not only process bills but also review, audit and settle Medicare cost reports. The bill processing function is essentially of a clerical and routine nature designed to provide statistics related to beneficiaries and providers. This process activity has little to do with the payment of program reimbursement under Part A. The payment of money results from the review of the cost reports submitted by the provider. This is a "knowledge" function using accounting theory and Medicare reimbursement regulations. Continuity of this function by having experienced personnel who are knowledgeable about the providers is an important asset in making accurate program payment. The cost reimbursement mechanism aids in providing a continuity of this "service" function.

Medicare Part B is covered by Section 1842(a) of the Act which authorized the Secretary to enter into contracts with carriers, including carriers with whom agreements under Section 1816 are in effect, to perform certain functions spelled out in Section 1842(a). Paragraph (b)(1) further specifies that contracts with carriers under Section 1842(a) may be entered into without regard to Section 3709 of the revised statutes or any other provision of law requiring competitive bidding.

Disadvantages

1. State laws may require State Governments to contract only with nonprofits. Should the decision be made that cost reimbursement will be utilized for States administering Title XIX, State laws must be analyzed to determine, which if any, States must contract with nonprofit agencies. Those States must be urged to obtain a change in their statutes. At this point, it is not known whether there are any States whose laws must be changed. Many fiscal agents processing claims on behalf of the States are operating on a profit basis.

2. Minimum incentive for cost effective management. Although there is a great incentive from the Government's standpoint, there is minimum incentive for efficiency on the contractor's part. Any efficiency in performance

merely reduces the cost which one might argue is contrary to the contractor's interest even though of benefit to the Government.

3. Does not lend itself to open competition. Cost reimbursement contracts generally are utilized by nonprofit and not-for-profit organizations who do not expect to return profit to investors. These contracts thus discourage profit-making organizations. Also, as a result of any unhealthy environment created in the non-HCFA portion of the contractor's business the Government may be required to absorb extremely high overhead costs from non-HCFA lines of business that would not be possible in a competitive market place.

B. Cost-Reimbursement Plus Incentive

A cost plus incentive fee contract is a type of cost-reimbursement contract. The fee is adjusted in accordance with the total allowable cost as compared with the target cost. The contract should always state the maximum fee payable and may refer to a minimum as well. This type of contract is used where development can be expected and the Government specifies the performance to be achieved.

Advantages

The advantages and disadvantages shown in Section A (Cost Reimbursement) are also generally applicable to cost plus incentive contracts after taking into account that cost plus incentive contracts are not presently being used in either Medicare or Medicaid.

1. Encourages efficiency. The mechanics of computing the incentive fee may lead to an understanding of why this type of contract would be more efficient than the cost contract. The target cost, the target fee, the minimum fee and the adjustment formula are agreed to prior to contract execution. The final fee will be higher than the target fee if the total allowable cost is less than the target cost. And, as expected, the final fee will be less than the target fee if the allowable costs exceed the target costs.

2. Promotes system enhancements (administrative). In addition to encouraging efficiency the contractor would not hesitate to encourage system improvements if the resultant savings are passed on to the contractor based on a predetermined and agreed upon formula.

3. Contractor cost effectiveness. The cost plus incentive contract encourages cost effective performance of all contracted functions as well as overhead.

Disadvantages

1. Additional Government audit required. A comprehensive audit of contractor costs must be conducted for all cost-reimbursement contracts. In addition, for cost plus incentive fee contracts, all items relevant to the computation of the final fee must be thoroughly examined.

2. Discourages system enhancements (program). Incentive fee or other types of incentives built upon cost contracts generally relate to the technological development or services being purchased. Savings in the administrative area are quickly calculated and passed on to the contractor. However, when one examines the use of cost plus incentive in an insurance operation, it is difficult to determine the program savings that would result from a system change. That is, it is difficult to calculate the program savings if a new screen is introduced into the system which improves the functional effectiveness of the entire system. Savings in the program area (which are much higher than administrative savings) would certainly not receive priority over normal operations, if the program savings are not converted on some basis to profit to the contractor. Unless there is a clear understanding of how the contractor would benefit from program savings, he certainly cannot be expected to upgrade his operation.

C. Firm Fixed Price

The firm fixed price contract is an agreement between the Government and the contractor to deliver specific services or products at a fixed dollar amount. This dollar amount is generally not adjusted whether or not the contractor has a cost overrun or underrun. From this standpoint, it is apparent that the fixed price contract can yield the contractor the greatest potential profit although at the greatest possible risk. This type of contract forces the contractor to accurately estimate the costs of carrying out the terms of the contract.

Medicare has used this type of contract for three experimental carrier contracts under Section 222 of the 1972 Amendments

to the Social Security Act. The States utilizing fiscal agents in carrying out their responsibilities under Title XIX have utilized firm fixed price contracts.

Advantages

1. Less Government control of day-to-day operations required. This type of contract is theoretically the easiest and least costly to administer from the Government's viewpoint. The contractor accepts all risks under the terms of the contract. There are generally no adjustments to the price of the contract regardless of the actual experience of the contractor. The costs of the contract are further lowered as Government oversight of the contractor's performance is minimum. For example, the contractor's accounting system need not be changed to accommodate the Government under fixed price contracts. Under cost type contracts, the Government may insist on changes in the contractor's accounting system so cost data can be properly accumulated. However, because of the need to assure a complicated service is adequately furnished beneficiaries the amount of oversight needed to maintain quality may not be dissimilar to that used by Medicare.

2. Lends itself to open competition. Fixed price contracts, because of the provision for profit are more appealing to more contractors than cost-type contracts, which may attract nonprofit contractors. Contractors can submit a bid with a profit figure to test the market and what the Government will accept. Should the contractor's bid be accepted because other bids are higher, the winning contractor would then have a built-in opportunity for profit. Selection of contractors is simplified through competitive fixed price process as compared to selection process for cost reimbursement type contracts.

3. Places risk on contractors. It is axiomatic that the firm fixed price contract places the risk on the contractor while the cost contract shifts the risk to the Government. This and the profit motive are perhaps the most important factors in selecting the type of contract to be used from both parties' viewpoints. The Government allows the contractor a profit as a trade-off to the risk involved. Once the contract is signed, all risks, except those specified in the

contract such as cost of living, acts of God, union management relations, etc., are not an administrative burden to the Government. Liquidated damages may be imposed should the contractor fail in carrying out terms of the contract.

4. Incentive to decrease administrative costs. The motivation for profit stimulates the contractor to decrease his administrative costs since savings accrue to him. While there is great incentive to decrease the contractor's administrative cost there is also some decrease in the administrative burdens borne by the Government.

5. Substantial number of qualified and interested organizations in the market. There is a large body of qualified organizations serving or available to serve Medicare and Medicaid interested in fixed price contracting. Experience indicates there is a viable and effective marketplace for fixed price contracts.

Disadvantages

1. Disruption to Title XVIII program. Since the inception of the Medicare program, the Medicare Bureau has utilized cost-type contracts and use of fixed type contracts may lead to disruption as new contractors enter Medicare processing. To moderate this disadvantage to Title XVIII many present contractors would undoubtedly be successful bidders under a fixed price arrangement.

2. Need more specificity in contracts. Because the contractor and the Government enter into a firm fixed price contract, it is mandatory that the contract set forth as many terms as possible governing the action of both parties in clear and exact fashion. Substantive specifications delineating the functions to be performed must be part of such a contract. Also the problem of what responsibilities should remain with central office and what should be delegated to the regional offices has to be addressed.

3. Higher probability of contractor bankruptcy increases risk to Government. Should the contractor offer a low fixed price bid to receive the contract or submit a price based on erroneous estimating, the possibility does exist that the contractor can become bankrupt. Bankruptcy can occur as well to contractors operating under any type of contract not as a result of functions

being carried out under contract to HCFA or the States, but as a result of other business activities. Under a fixed price contract, the contractor must absorb any overruns while under a cost contract additional burdens which a contractor may be forced to assume in the course of other business activities, could materially affect the total cost to HCFA, e.g., increased overhead.

D. Fixed Rate

A fixed rate price per unit contract fluctuates in total price according to changes in volume, with the unit cost remaining the same throughout the life of the contract. A firm fixed price contract does not change because of volume change. One alternative to a fixed price per unit is a sliding scale based on volume.

Advantages

The advantages of this type are very much the same as those for firm fixed price but certain other advantages exist:

1. Contractor not affected by fluctuations in workload. The workload under Medicare can be reasonably estimated within safe planning limits based on the experience under the Medicare program since its inception and the resulting statistical data base. The number of persons eligible for Medicare benefits can also be reasonably estimated.

2. Provides for comparison of contractors. The use of a unit cost for comparison between Medicare contractors has been a most important tool for measuring contractor performance. Although the experience up to now in Medicare has been with cost contracts, the same ease of comparison would be available if a fixed unit price was established.

Disadvantages

The disadvantages shown for firm fixed price contracts also apply to fixed rate contracts, with the following additions:

1. Decreases risk to contractor. The use of a fixed unit price decreases the risk to the contractor over the firm fixed price contract by eliminating the possibility of substantial value increases. For

example, in the case of the Maryland negotiated fixed rate contract under Section 222, the price per unit is volume sensitive. If the volume goes down the price goes up and vice versa. There does not appear to be as much risk for the contractor under a fixed unit price arrangement.

2. Requires detailed standards for definition of unit. The definition of unit presents a problem for both Titles XVIII and XIX. While it may well be the case that adequate standards could be devised for Medicare, the problem becomes more difficult for Medicaid because of the number of options available to States for medical services. It would appear that standards might be necessary on a State by State basis. Because the contractor will be paid on the number of claims processed the inclination might be strong to promote increases in the number of claims processed through the operation and this would require close monitoring.

3. No incentive to decrease program costs. Reimbursing on this basis might hinder the contractor from taking additional steps in the claims process calculated to complete the claim properly. Whether this adds to program costs or not at this stage is not apparent. But, if lower program costs result from a "sloppy" operation, it can be taken for granted that more appeals will be generated. Utilizing the unit price contract would perhaps require as much review of the contractor's operation as would be required if the operation were carried out under a firm fixed price per contract.

E. Insuring Agreement Contracts

The contractor agrees under insuring agreement contracts to provide specific medical coverage to eligible recipients for a prepaid fixed fee. This type of contract places the contractor at risk for all costs, program and administrative. If the prepaid charges are less than the outgo in benefits, the contractor has to absorb the deficit, although the rate will be subject to negotiation for the succeeding year, taking future cost trends and reserves into account. There have been insuring agreements in Arkansas, California, Louisiana, Florida, Maine, North Carolina and Texas. In Pennsylvania there has been an insuring agreement contract for the administration of Medicaid drug programs. California also entered into an insuring agreement in 1974 for dental services and in April 1975, North Carolina entered into an insuring agreement

covering all aspects except for program policy, eligibility determination, inspection and certification of providers, and processing drug claims.

This type of arrangement theoretically offers great incentive for contractor efficiency since the contractor would seek to maximize profits by decreasing costs. On the other hand, there is the risk that in an effort to minimize costs the contractor may incorrectly or improperly deny payment for services. The most important disadvantage, however, is the great risk involved in this type of arrangement.

The Medicaid experience with insuring agreement contracts has been less than satisfactory. While this is a contracting option for the Medicare and Medicaid programs, the extent of risk is so great that it is not a viable contracting option for HCFA.

III. Summary of Options

- Continue current programs with additional experiments.
- Allow Medicare to mix types of contracts as appropriate; continue to allow States under Medicaid to choose any method.
- Mandate a new method for Medicare; continue to allow States under Medicaid to choose any methods.
- Mandate one method to be used by Medicare & Medicaid.

IV. Discussion of Individual Options

Option 1: Continue Current Programs with Additional Experiments

For Medicaid, all contracting is of a fixed price nature: fixed price per claim, fixed price per contract or insuring agreements. All contracts are of the cost-type for Medicare except two or three firm fixed price experiments under Section 222.

Advantages

- No disruption of services--There would be no disruption of services to the public except for those contracts being changed to firm fixed price for Medicare operations.

- No disruption to contractors and Government--Same as above.

- Greater control by the Federal Government--From the Medicare viewpoint, the requirement for cost reimbursement contracts involves a greater degree of participation by the Federal Government.

Disadvantages

- Low incentive for efficient management. There would be no incentive for the Medicare contractors to strive for efficiency.

- Continuance of the various types of contracts for Title XIX. The 53 States and territories operating Title XIX programs can enter into any type of competitively procured contract for claims processing. Use of one type of contract does not limit a State's options in future or concurrent contracting. Title XIX claims processing may be done in whole or in part by either the contractor(s) or the State Government.

Costs/Savings

There should be cost reductions in the Medicaid program since the requirements for free and open competition have fostered the introduction of advanced technology, resulting in more efficient claims processing to achieve accurate, nonduplicative payments and to serve as a deterrent to fraud and abuse. The Medicare, program should also realize lower costs as competitive procurements are used more extensively.

Steps required for implementation

No additional steps are required.

Timetable

No restrictions.

Feasibility

Legislative considerations.

None required.

Administrative Considerations.

None.

Budgetary Considerations.

No significant change.

Political/Social considerations.

None.

Option 2: Allow Medicare to mix types of contracts as appropriate; continue to allow States under Medicaid to choose any method.

This option would require change only in the Medicare operation since States can presently select any method of reimbursing the contractors under either Title XIX or Section 1110 and 1115 of the Social Security Act.

Advantages

- Lower administrative cost. To the extent that cost type contracts are replaced by firm fixed price contracts, the Medicare administrative expenditures would decrease. With respect to Title XIX, as a result of the requirement for free and open competition it is expected that the present trend of reduced claims processing costs will continue.

- Shifting risk to contractor. The contractor operating under a fixed price should have to assume the risks of operations within the agreed price figure. This tends to promote efficiency at the contractor level not present when cost type contracts are utilized.

Disadvantages

- Indicates no room for improvement. To continue with the present policy on administering Title XIX would signify satisfaction with the present mode.

- Lack of uniform procedures. Implementation of this option would acknowledge that contracting procedures under Medicare and Medicaid do not need to be uniform.

- Dual system under Medicare. Use of both cost reimbursement and fixed price contracts would necessitate maintenance of two systems for administering contracts.

Costs/Savings

There would be no appreciable savings in program costs but some administrative costs savings when Medicare contracts become firm fixed price.

Steps required for impelmentation

Legislation is required for Title XVIII if the decision is made to add firm fixed price contracting as a permanent option. The only authority now derives from the experimental provision in Section 222 of Public Law 92-603.

Timetable

After a decision is made to terminate a Part B contractor under a cost type contract, less than a year is required to select and have operating a new contractor selected under a firm fixed price contract. For example, where a single carrier under cost type contract is being replaced by a single carrier under a fixed price, the following schedule would apply.

Jan. 1 - Announcement of termination

Mar 1 - RFP issued

April 1 - Pre-proposal conference

May 1 - Proposals submitted

May 15 - Evaluation completed

June 1 - Announcement of award

June thru Oct. - Implementation phase

Nov. 1 - New carrier operational

Feasibility

Legislative considerations

This option could be implemented initially without legislative change since Medicare could use Section 222

experimental authority to enter into fixed price contracts. However, legislation would be necessary to permit permanent use of the option by Medicare.

Administrative Considerations

Administrative problems would remain at a minimum should this option be selected.

Budgetary Considerations

No significant budgetary impact.

Political/Social considerations

Medicare contractors currently operating under cost reimbursement contracts would probably lobby against competitive procurement as a basis for selecting Medicare contractors. Also, there would be some confusion for the beneficiary population as contractors are changed more frequently under competition.

Option 3: Mandate a new method for Medicare; continue to allow States under Medicaid to choose any methods.

Because Medicare has been operating under cost contracting, the option is limited to using competitively bid firm fixed price contracts. Also, the Medicare contractors have to a large degree developed efficient methods for carrying out functions of Title XVIII. Therefore, the Medicare contractors at this point in time should be well prepared to develop data necessary for competing in fixed price/fixed rate contracting.

Advantages

- A free and open competition. Free and open competition would be fostered among prospective Medicare contractors, encouraging the infusion of advanced technology. It becomes an attractive contract for a contractor who wants to realize a high profit while at the same time encouraging the contractor who has kept his costs competitive.

- Less Government administration. This type of contract is the least complex and costly to administer by the Government.

- Risk on contractor. The firm fixed price contract places the risk on the contractor. The risk versus the contractors profit motive are important factors in selecting this type of contract from the point of view of both parties.

- Innovative approaches. Innovative approaches to claims processing problems will be generated because it is in the contractor's interest to streamline the operation.

Disadvantages

- Change in contracting procedures for Title XVIII. Traditionally, Medicare programs have utilized cost type contracts. A significant change in contracting arrangements would result in disruption of the established procurement process.

- Less flexibility. Contract flexibility is reduced because contractors and the Government enter into a firm fixed price contract setting forth all terms governing the action of both parties in clear and concise language.

- Risk of contractor failure. If the contractor underbids on the fixed price contract, the possibility exists that the contractor may be forced out of business.

Costs/Savings

- Reduced administrative costs. There is a reduced Government administrative burden under a fixed price contract resulting in administrative cost savings.

- Program budgeting. Long term planning is enhanced because under a fixed price contract the costs are known at the time of contract award.

- Competitive environment. Because of the free and open competition leading to a fixed price contract, each bidder will attempt to provide service at his lowest competitive cost. In most cases, this will result in a lower contract cost.

Steps Required for Implementation

- Outline objectives

- Define standards

- Set forth contractual requirements
- Detail description and ranges of processed claims
- Train administrative staff
- Initiate free and open competition bidding
- Legislative change

Timetable

- Outline objective (2 months after)
- Legislative proposal (2 months after)
- Define standards (9 months after adoption completed)
- Set forth contractual requirements (6 months after legislative enactment)
- Detail ranges of processed claims (6 months after legislation)
- Train administrative staff (6 months after legislation)
- Initiate free and open competitive bidding (6 months after legislation is enacted)

Feasibility

Legislative Considerations

No changes are required for Medicaid; however, there has to be change for Medicare. At the present time the law provides that the Department has to use cost-reimbursement contracts. Since it is not feasible to use Section 222 indefinitely a change in the law is necessary.

Administrative Considerations

Since the requirement for monitoring the contractor under fixed price is considerably less than for cost-reimbursement contracts, the Government over-sight is reduced. On the other hand, additional effort must be made to properly delineate functions to be performed and to issue detailed RFPs.

Budgetary considerations

The administrative cost of carrying out Title XVIII under fixed price would be significantly lower than under cost reimbursement.

Political/Social Considerations

Current contractors may not bid a fixed price contract. This could have a negative impact on the business environment. Medicare contractors would likely bring pressure to keep things as they are. Also, the loss of the Medicare portion of the Blue Cross/Blue Shield's business could affect their private sector business.

If there is a new contractor serving an area that was previously serviced by another (for example, in Medicare that could have been one contractor serving an area since 1965), there may be some confusion and criticism. The Medicare program has about 25,000,000 beneficiaries, the bulk of which are over 65 and the Medicaid program has about 25,000,000 spanning all ages.

The free and competitive mode of procurement yielding a lower administrative cost should meet with the approval of the taxpayer who pays for the Medicaid and Medicare programs.

Option 4: Mandate one method to be used by Medicare and Medicaid

Under this option a single method of compensation or reimbursement would be mandated for use by both Medicare and Medicaid for reimbursing contractors engaged to perform functions and duties under Title XVIII and Title XIX. The single method to be applied would be the firm fixed price or fixed rate type of reimbursement for the term of the contract.

Advantages

- It appears clear from the experience of the State Medicaid agencies in contracting for services in Title XIX, from the experience gained thus far in Medicare with the Section 222 prime contractor experiments, and also from the substantial ADP subcontracting experience in Medicare Part B, that fixed price or fixed rate contracts are viable and

effective reimbursement methods and that there is in the market a substantial number of highly qualified organizations, including the current fiscal intermediaries and carriers in both programs.

- The fixed price or fixed rate methods facilitie the competitive selection of the contractors. These modes of selection are advantageous to both programs in letting essentially service oriented contracts as opposed to construction, product or manufacturing oriented contracts. They place the contractor at risk while at the same time providing the opportunity for profit. They place the burden and responsibility for performance squarely on the contractor in a way not nearly as effectively possible under the cost type contracts. The definition and specificity of services and deliverables, the performance criteria and measures established in the contract, and the provisions for assessing liquidated damages for poor performance, all provide the framework for more effective program administration while maintaining a more business like and arms length relationship with the contractor community.

- The overall objective of more efficient and effective administration would be best served under fixed price or fixed rate contracting.

- Overall contracting procedures and monitoring of performance of contractors would be enhanced.

Disadvantages

- There are issues to be addressed in the application of these methods. A principal issue is moderating the impact of change in both programs by developing and applying policies for implementation that would be the least disruptive initially and at the time of future change or recompetition. This can be achieved in part through the manner in which the geographical area or workload to be let is determined, the term of the contracts to be let which can vary to accommodate to the sensitivity of the workload, the schedule of implementation and recompetition to be followed. Also to be addressed is the issue of flexibility to the programs to be able to effect changes by new statutes or regulations, to modify or terminate for the convenience of the programs. These considerations apply equally to the conditions for considering change

orders which might be the basis for modifying the fixed price or rate.

In the Medicaid program the States now have the authority and autonomy to select whatever method of compensation or reimbursement they may choose, e.g., cost, cost plus incentive fee, fixed price, etc. They also have the authority to let contracts which are "insuring agreements" and which put the contractor at risk with respect to the program payments. This autonomy and authority does not exist in the Medicare program.

- In both programs, inpatient services and other services reimbursed on a cost or cost related basis require a substantial amount of professional capability in the area of cost report review, audit, and negotiation of final settlements. This also requires considerable expertise in the principles of provider reimbursement applicable in both programs and knowledge of general accounting principles and practices. These essentially professional activities of audit and reimbursement constitute a critical element in the final determination of a substantial majority of the benefits payments in both programs. The nature of these professional services are such that they are not as amenable to fixed price reimbursement or fixed price contracting as are the bill or claims processing services.

Costs/Savings

Mandated fixed price or fixed rate contracting would result in significant administrative cost savings under Medicare.

Steps Required for Implementation

Implementation steps would be the same as outlined under option 3.

Timetable

The timetable for implementation would depend upon how quickly necessary legislation could be enacted. With that exception, the timetable for accomplishing each implementation step would be the same as shown for option 3.

Feasibility

Legislative Considerations

This option would require that legislation be sought to provide the Secretary with the authority to mandate the fixed price method for reimbursing contractors in both programs. The legislative authority should be flexible and permit the Secretary to determine the most overall program and cost effective way for reimbursing for the professional cost report audit and settlement functions.

Administrative Considerations

The Secretary would be required to develop, test and determine the most effective reimbursement method for these services before mandating by regulation the method to be applied. While firm fixed price seems to be the ultimate preferred method for contracting, there are situations where a fixed rate might be more appropriate. Thus, for the time being both methods should be used and HCFA should develop criteria for when each type should be used. The criteria would be applicable to both Medicare and Medicaid contracting. The objective would be to apply the fixed price or fixed rate methods to all services let under contract. This would include professional audit and reimbursement services but the flexibility for testing and evaluating would be provided before the Secretary made a final determination.

Budgetary Considerations

As indicated under advantages, administrative costs should be significantly less if all Medicare contracts were based on competitive procurements. The budget process itself would be simplified considerably under fixed price and fixed rate contracting as compared to cost contracting.

Political/Social Considerations

All of the items listed under option 3 would apply here as well.

INTEGRATION OF MEDICARE AND MEDICAID
CONTRACTING PROCEDURES

I. Statement of the Issue

At the present time, the Health Care Financing Administration (HCFA) utilizes five different contracts in administering the Medicare and Medicaid programs. These include: (1) Medicare prime contracts (with intermediaries and carriers), (2) Medicare subcontracts (between intermediaries/carriers and other organizations), (3) Medicaid contracts (between States and fiscal agents), (4) Medicaid subcontracts (between State fiscal agents and other organizations), and (5) Medicaid Management Information Systems Contracts. In utilizing each of these five contracts, HCFA plays a different role. Additionally, the substance of each contract and the contracting process differs widely. The issue is twofold: whether HCFA should play an identical role with respect to the five contracts and whether specific elements within the contracts and contracting process should be standardized. Standardization of HCFA's role and specific contract elements would promote a more consistent application of policy within the program, reduce administrative complexity of the contracting function, decrease confusion among potential bidders, and encourage more potential offerors to enter the marketplace.

II. Background Discussion

A. Medicare Prime Contracts

Medicare enters into contracts with carriers to provide for the administration of benefits under Part B (Supplementary Medical Insurance Benefits for the Aged and Disabled). These contracts are entered into without regard to any provision of law requiring competitive bidding. With respect to administration of payments under Part A (Hospital Insurance Benefits for the Aged and Disabled), Medicare enters into agreements with agencies or organizations (intermediaries) which have been nominated by any group or association of providers of services. It is legislatively provided that carriers and intermediaries will be paid their costs of administration as determined by the Secretary to be necessary and proper for carrying out the functions covered by their contracts. The existing agreements between the Secretary and the carriers/intermediaries stipulate that they shall be paid their cost of administration under the principle of neither profit nor loss.

These prime contracts are entered into under the authority of Title XVIII, Sections 1842 and 1816 of the Social Security Act and governed by regulations under 20 CFR 405.672. They are for 1-year terms and can be renewed each year for an indefinite period of time.

B. Medicare Subcontracts

Medicare contractors (intermediaries and carriers) perform some of their functions by subcontracting for outside assistance. The requirements surrounding the subcontracting policy and procedures are set forth in all Medicare prime contracts in the articles titled "Subcontracting", "Prior Approval and Prior Notice for Subcontracting and Data Processing Changes" and "Data Processing". Medicare also issues specific instructions to contractors regarding the process to be followed in awarding subcontracts. Failure by the contractor to abide by the contract, instructions or administrative policy can result in withholding of administrative funds or prime contract termination. In awarding subcontracts, contractors are expected to procure property and services from responsible sources at fair and reasonable prices calculated to result in the lowest ultimate cost to the Government. To achieve this objective, competitive proposals are to be used to the maximum practical extent.

C. Medicaid Contracts

Medicaid is a State-administered Federal grant-in-aid program for medical assistance to eligible recipients. Aspects of the Federal program to be administered in a given State are enumerated in a State Plan, which addresses how and to whom the selected medical services will be provided. Only through State Plan approvals, Federal financial participation (FFP) denials for noncompliance, or penalties for certain infractions, can the Medicaid Bureau control administration of the program in the States. The Bureau does not administer Medicaid directly; the States do. In doing so, the State may contract directly with another organization, known as a "fiscal agent" to perform certain functions such as processing claims. These fiscal agent contracts are governed only by the general procurement rules in 45 CFR Part 74 and any adherence to specific Medicaid procedures by the States is strictly voluntary. Thus, the substance and award of fiscal agent contracts vary widely.

D. Medicaid Subcontracts

In some instances a State fiscal agent may subcontract a portion of its function to another organization. These fiscal agent subcontracts are subject to minimal Medicaid regulations and are rarely monitored by the States.

E. Medicaid Management Information Systems Contracts (MMIS)

States may enter into contracts with organizations for the design, development or installation of mechanized claims processing and information retrieval systems. Specific Medicaid regulations governing the award of MMIS contracts are included in 42 CFR 450.90. States may receive 90 percent FFP for development and 75 percent FFP for operation of an MMIS system.

If a State combines the operations of an MMIS system with the functions of a fiscal agent, it is known as a "combination" contract and subject to MMIS regulations as well as regulations pertinent to fiscal agent contracts.

III. Discussion of Issues

There are six major issues concerning the substance and award of contracts. These issues include: (1) cost effectiveness of proposed contract, (2) life (term) of contract, (3) contract extensions, (4) start-up period for phase-in of new contractors, (5) the evaluation process, and (6) cost evaluation criteria. The three issues concerning HCFA's role in the contracting process include the documents to be reviewed/approved, the level of review/approval and the time frames for review/approval.

A. Issues Concerning Substance and Award of Contract

1. Should HCFA require that cost/benefit analyses be performed before permitting a contract/subcontract to be pursued?

Current Situation

Medicare Prime Contracts: Cost/benefit analyses not required
Medicare Subcontracts: Cost/benefit analyses required
Medicaid Contracts: Cost/benefit analyses not required
Medicaid Subcontracts: Cost/benefit analyses not required
MMIS Contracts: Cost/benefit analyses required

During the initial selection of Medicare contractors, qualification criteria were developed to identify those contractors whose selection would provide the most potential for cost and performance effectiveness. Renewals of these initial contracting arrangements have been dependent upon the contractor continuing satisfactory cost and performance. Medicare contractors are evaluated annually and subsequent to this annual evaluation a listing is prepared of those contractors whose performance is less than satisfactory. Contractors on this listing are then normally given a limited contract renewal, e.g., the renewal is for a period of 1 year with no option to renew unless cost and performance improves during the 1-year contract period. Section 1842 of the Social Security Act and Section 14 of Public Law 95-142, as it modifies Section 1816 of the Act, give the Secretary flexibility in determining the number of prime contractors and who should be selected as a contractor.

Medicare, however, requires its prime contractors to perform cost/benefit analyses before they are allowed to subcontract. The most common subcontract is for electronic data processing (EDP) services on the part of carriers. When a Medicare carrier declares its intention to subcontract its claims data processing activity, it must, as required by agreement and instructions, undertake a detailed analysis of the current operating situation. This analysis should set forth the current operating difficulties, requirements for eliminating these difficulties, requirements for upgrading the present EDP system, the estimated cost that would be incurred, the time that would be required, and specific obstacles to such upgrading, such as personnel or hardware problems. In its proposed solution, the carrier is required to design data systems specifications, equipment performance requirement specifications, and other specifications to foster free and open competition and opportunity to responsible suppliers. Under this contractual requirement, the carrier would submit documentation indicating the need to subcontract where the proposed subcontract would require prior approval.

Obviously, in evaluating the cost effectiveness of proposed systems contracts, consideration is to be given to the impact on program dollars, as well as administrative costs.

Since the inception of Medicare, there has been an evolution of methods used to process an increasing volume of Medicare claims. Initially, many contractors relied primarily on processes which required minimal funds for, and application of, EDP hardware and software. Major technological changes,

requiring substantial investment of Government funds, benefited the Medicare program by providing major qualitative and quantitative improvements in the Medicare claims process. However, at some given point in time it is assumed that a major systems change or the delegation of data processing to a subcontractor may not produce the same long-range benefits in program and administrative dollars to the Medicare program as they once did. For these reasons the Medicare Bureau issued an instruction to its contractors that when a contractor requests a change to an EDP facilities management subcontract, such proposed change will be reviewed to determine whether there is a clear indication of an early return on initial investment and/or program need for the change. The requirement of "early return on investment" is defined as recovery of nonrecurring implementation costs in administrative cost reductions within a 2-year period.

Medicaid does not specifically require any cost/benefit analysis before a State enters into a fiscal agent contract; nor does it require the States to demand that the fiscal agent perform a cost/benefit analysis before subcontracting. Historically, the Department has interpreted the Medicaid statute to mean that States have full authority to determine how decisions on contracting will be made. The requirements of 45 CFR Part 74 do require a grantee (e.g., the State) to review proposed procurement actions to avoid purchasing unnecessary or duplicative items, and to analyze whether lease or purchase provides the most economical, practical procurement, but this does not necessarily mean a cost/benefit analysis.

Medicaid does require States to perform cost/benefit analyses for 90 percent FFP with respect to development of MMIS. Provisions of 42 CFR 450.90 require advance planning documentation which must contain "the estimated cost including a cost/benefit justification appropriate to the scope and cost". Advance planning documents must be approved by the Medicaid program. Medicaid, with its new statutory authority for MMIS, implemented these regulations in order to effectively monitor and control the large amounts of money spent for development of MMIS.

Options

1. Require all contracts to be preceded by cost/benefit analyses.
2. Require all contracts, except Medicare prime contracts, to be preceded by cost/benefit analyses.
3. Maintain the current requirements for cost/benefit analyses.

Advantages/Disadvantages

In the administration of any public program, cost maintenance is always a principal consideration. Requiring that any proposed contract be documented to support cost effectiveness would help assure that a change to a contracting/subcontracting situation would result in lower administrative costs. This is generally the case in most proposed subcontracts approved under Medicare.

On the other hand, if cost effectiveness did not have to be justified, States and contractors might be more prone to explore and test methodologies and techniques that might be available only under contract. Furthermore, where a State or Medicare contractor is experiencing problems inhouse and subcontracting is determined to be the only alternative to resolving these problems, the solution may be more costly. In this situation, the concern is with getting the best price available through competition and considering impact on contractor/State operations rather than that the subcontract be cost effective.

The current situation regarding cost/benefit analysis is inconsistent and provides no basis for maintaining control over administrative costs within HCFA programs. It provides no incentive to the States to reassess their current contracts with respect to cost effectiveness.

2. Should HCFA mandate a specific contract life (term) and what should this contract life be?

Current Situation

Medicare Prime Contract: 1 year with automatic 1-year renewal
Medicare Subcontracts: 2 years with option to extend 1 year
Medicaid Contracts: Varies State by State
Medicaid Subcontracts: Varies State by State
MMIS Contracts: Varies State by State

Medicare prime agreements with the respective intermediaries and carriers are for a 1-year term ending each September 30, and subject to an automatic renewal period of 1 year, unless appropriate notice not to renew is given to the opposite party. Traditionally, however, various provisions are renegotiated annually so that from one year to the next, the prime agreements do not remain static.

At the inception of the program, Medicare subcontracts, particularly those pertaining to claims data processing, were for extended periods (e.g., 6-8 years). However, the Medicare Bureau's experiences during recent years precipitated downward modifications of the subcontract term with the purpose being to increase competition in this very limited and sophisticated field. The Medicare Bureau's efforts in this regard resulted in significant decreases in the bid price per claims processed in the successive procurements.

As early as 1973, the Medicare Bureau determined that it would best serve the interests of the Government and foster competition in the facilities management EDP arena to limit the subcontracts to 2 years plus 1 optional year term. The so-called Perkins Committee Report on June 21, 1974, agreed with this position. All of the most recent Medicare carrier facilities management subcontracts are now for a basic 2-year operational term with an option to the carrier to extend the term for an additional year, subject to approval by the Secretary.

Medicaid fiscal agent contracts in the States range from 1 to 5 years, usually with a base period of 2 or 3 years with additional 1-year renewal options. However, there appear to be, or have been, some fiscal agent arrangements for extended periods in certain States without the benefit of a periodic competitive procurement. Regulations require that the contracts must be written and must establish provisions and criteria for the contract's extension, renegotiation, and termination; Medicaid regulations do not specify a contract life or term. This same situation exists for Medicaid subcontracts.

MMIS contracts run from 6 months to 1 or more years depending on whether the system is being developed or operated.

Options

1. Mandate the same contract life for both contracts and subcontracts.
2. Mandate different contract lives for contracts and subcontracts.
3. Mandate a contract life to standardize Medicaid contracts and subcontracts.
4. Continue with the current situation.

Term of Contract Life

1. 1 year + 1-year option
2. 2 years
3. 2 years + 1-year option
4. 2 years + 1 year + 1-year option
5. 3 years
6. 3 years + 1-year option
7. 4 years
8. 5 years

Advantages/Disadvantages

Standardizing the contract life for each type of contract provides consistency within the programs. It also increases competition; potential offerors know that the ground rules are the same for all contracts of a particular type and can organize their resources accordingly. On the other hand, standardizing the contract life for all contracts/subcontracts does not take into account the differences between the Medicare and Medicaid programs and the purposes for their contracts. Since Medicare prime contracts are not competitively bid, there is no clause providing for termination for convenience; termination is only for cause. Thus, if prime contracts were negotiated for longer than a 1-year period, the Government's flexibility in administering the program would decrease. On the other hand, Medicare subcontracts may be terminated at the convenience of the Government and thus may be terminated at anytime during the contract life. Therefore, longer term subcontracts are desirable to increase competition. Medicaid, on the other hand, has to deal with contracting within the State environment which includes State law, legislative and budget cycles and State politics. MMIS contracts can be for development of systems as opposed to operation of programs, thereby requiring different time periods for contracts.

In general, short contracts (e.g., 1 year) tend to decrease competition because potential contractors are reluctant to invest the time and resources to compete. In addition, administrative costs to the program are increased since contracts must be prepared and awarded on a yearly basis. Long contracts (e.g., 5 years) may also decrease competition since they usually carry many contingencies for which contractors do not want to take the risk. Long contracts also decrease the flexibility to change contractors when it is desirous to do so. Three to 4 year contracts tend to minimize the effect of disruptions to program operations while promoting competition.

3. If a contract life is mandated should the contract be allowed to be extended beyond the contract period?

Current Situation

Medicare Prime Contract: Extensions entered into on behalf of the Secretary
Medicare Subcontracts: Extensions allowed in exceptional cases to meet program needs, with approval of the Secretary
Medicaid Contracts: Extensions allowed, with Federal approval
Medicaid Subcontracts: Extensions allowed, no approval required
MMIS Contracts: Extensions allowed with approval of Medicaid Bureau

A distinction is to be made between the terms "extension" and "renewal" in discussing continuation of an existing contract beyond its initially defined term. A renewal implies an agreement between the contracting parties to again enter into a contracting arrangement for a similar purpose and period without competition. An extension is generally agreed to by the party receiving the services in order for that party to meet a short-term need beyond the defined termination date. Extensions are not generally competed.

Medicare permits renewals of existing prime contracts since these contracts are not entered into competitively. Medicare does not permit renewal of subcontracts. Extensions, however, are allowed.

Options

1. Contracts should not be extended beyond the contract term.
2. Contracts should be allowed to be extended.
3. Contracts should not be extended beyond the contract period except under special circumstances as specified by the Administrator.

Advantages/Disadvantages

At the present time, all contracts may be extended although prior approval of extensions varies with the type of contract. Enabling contracts to be extended provides flexibility to the program in unusual circumstances. An example of this would be where a Medicare contractor is changing the incumbent systems subcontractor and the newly selected subcontractor is unable to install an operative system prior to the termination of the existing subcontract. An appropriate

extension would be granted to provide for continuation of operations by the incumbent subcontractor pending installation of the new systems.

On the other hand, unlimited extension of contracts would violate the requirements for competition.

4. Should a minimum start-up period for phasing in new contractors be mandated?

Current Situation

Medicare Prime Contracts: No minimum start-up period required
Medicare Subcontracts: No minimum start-up period required
Medicaid Contracts: No minimum start-up period required
Medicaid Subcontracts: No minimum start-up period required
MMIS Contracts: No minimum start-up period required

Neither the Medicare nor Medicaid program requires a minimum start-up period for phasing in a new contractor/subcontractor although they have recommended that sufficient time be allowed to accomplish this task. "Sufficient time" has varied among contracts/subcontracts from 3 months to 1 year.

While Medicare does not mandate an across-the-board minimum start-up period for phasing in new subcontractor systems, its Request for Proposals (RFP) guidelines recommend a 4 to 6 month system implementation period, and these parameters are generally adhered to between the contracting parties. The agreed to parameters in fact become a part of the contract document.

With respect to Medicaid, the length of time for implementation of a new contractor depends on the State's Medicaid program, the services being contracted, the State's capabilities, etc.

Options

1. Do not mandate a minimum start-up period.
2. Mandate a start-up period for each type of contract.

Advantages/Disadvantages

Difficulties have developed on occasion where there has been slippage in the overall procurement schedule and the contracting parties agree to a shortened implementation period to compensate for the slippage. Experience has shown that a short implementation period usually results in problems being solved during

the operational period rather than during implementation. This causes severe backlogs which results in overtime, poor morale, a bad image and increased costs. This situation should be avoided and every emphasis should be placed on insuring a trouble-free system when it becomes operational. On the other hand, an extended phase-in period can also result in increased costs because two contractors are being reimbursed for the same functions.

5. What type of evaluation process should be used in awarding contracts?

Current Situation

Medicare Prime Contracts: One-step process
Medicare Subcontracts: One-step process
Medicaid Contracts: Varies, one step or two step
Medicaid Subcontracts: Varies
MMIS Contracts: Varies, one step or two step

The one-step approach incorporates both technical and cost criteria into the total number of points awarded in the evaluation of a proposal. This approach can be tailored to emphasize technical or cost criteria as the determining factor in awarding a contract. Thus, the offeror with the lowest cost bid may not necessarily be awarded the final contract.

In the two-step approach, proposals are first evaluated for technical acceptability. Once proposals are found to be technically acceptable, their costs are evaluated. The contract is then awarded to the technically acceptable bidder with the lowest costs.

Options

1. Maintain existing situation.
2. Mandate the use of one type of evaluation process for all contracts.
3. Mandate the use of one type of evaluation process for each type of contract.
4. Set conditions to determine when to use each type of evaluation process.

Advantages/Disadvantages

The conditions under which one or the other method is employed are as important as the process itself. Each procurement must be evaluated on its merits to determine the results to be

achieved, the extent of competition sought and the better method to achieve the desired results. Limiting the process to either the one-step or two-step in all cases is much too restrictive with no offsetting benefits. Conversely, allowing the evaluation process to be chosen at random permits bias to be built in and may, under certain circumstances, achieve less than the best results.

Mandating the use of one specific evaluation process for each type of contract provides consistency and promotes the validity of the contracting process.

6. Should HCFA require that the impact of a proposal on program costs and total administrative costs be included as a major element in awarding contracts?

Current Situation

Medicare Prime Contracts: Impact required
Medicare Subcontracts: Impact required
Medicaid Contracts: Impact not required
Medicaid Subcontracts: Impact not required
MMIS Contracts: Impact not required

Medicare does evaluate a prime contractor's performance which includes the cost of operating as an intermediary or carrier. In evaluating subcontracts, Medicare requires the offeror to project the impact of the subcontract on the contractor's administrative costs in order to determine the total cost of award to the Medicare program.

Medicaid does not require States or fiscal agents to determine the impact of an award on program or total administrative costs although this has been done in certain cases.

Options

1. Require that the impact of an offeror's bid on program and total administrative cost be considered in making an award.
2. Consider only the offeror's bid in making an award.

Advantages/Disadvantages

In many cases, it is difficult to assess the impact an offeror's bid will have on program and total administrative costs. The difficulty in determining the impact may lead to charges of arbitrariness and capriciousness, thus tarnishing the credibility of the evaluation process. On the other hand, by assessing the impact, a total cost to the Government can

be realized and a true comparison of offers can be made. In addition, assessing the impact may prevent offerors from submitting nonrealistic low bids in order to win the contract.

B. Issues Concerning HCFA's Role in the Contracting Process

1. What documents in the contracting process should receive prior review and approval by HCFA?

Current Situation

Medicare Prime Contracts: Not applicable, not competitively entered into
Medicare Subcontracts: All documents
Medicaid Contracts: Contract only
Medicaid Subcontracts: Contract only
MMIS Contracts: All documents

The documents in the contracting process include an advance planning document, request for proposal, evaluation plan, evaluation of proposals, justification for selecting winning bidder and the final contract. Also included are contract modifications.

Medicare prime contracts are not competitively bid; the contract document is executed on behalf of the Secretary and thus there is no approval mechanism since the Government is one of the contracting parties. Modifications, however, are approved and processed in the central office.

The Medicare carrier agreement in Article XVIII B requires carriers to obtain prior approval by the Secretary before entering into any subcontracts that would exceed specific monetary threshold amounts. These threshold amounts range from $50,000 up to $165,000 and are based upon the carrier's total administrative costs. Article XX entitled "Data Processing" requires that the carrier, in submitting data processing proposals, shall include: (1) the design specifications and cost analysis of the proposed change and (2) documentation that such change or process is needed for cost effectiveness. Article XX B requires that the carrier shall design data systems specifications, equipment performance requirements specifications, and other specifications to foster free and open competition and opportunity to responsible suppliers, including manufacturers, leasing companies and third-party vendors. Under this contractual requirement, the carrier would submit documentation indicating the need to subcontract where the proposed subcontract would require prior approval.

All requests for prior approval of EDP subcontracts and changes are submitted to the central office. In reviewing the carrier's proposal to subcontract, approval is contingent on the carrier meeting a requirement that any nonrecurring implementation costs be recovered in administrative cost savings during the first 2 years of the subcontract.

If the carrier proposal to subcontract for EDP services is approved, the carrier will then proceed to develop an RFP which must be submitted to central office for approval before release.

The Medicare team will review the RFP against the Bureau's RFP guidelines, principally to assure that the specifications are accurate and realistic and that the RFP is not biased to any existing system and will promote competition to the maximum practical extent.

Upon approval of the RFP by the Medicare Bureau, the carrier is then required to publicize the release of this document which is normally accomplished through a notice in the Commerce Business Daily. In conjunction with the development of the RFP, the carrier develops a formal Proposal Evaluation Plan (PEP) which is subject to the prior approval of the Medicare Bureau before opening of vendor proposals by the carrier. The Medicare Bureau review of the PEP is to assure effective and comparable evaluations of proposals submitted by competing vendors.

Upon receipt of all vendor proposals, the carrier will evaluate them against the RFP and PEP, and that vendor which receives the most points under the evaluation plan would be recommended as the successful vendor. These procurements involve a one-step process and the vendor with the lowest cost proposal will not necessarily be selected.

Upon completion of the carrier's review and evaluation of proposals received, the carrier will submit its formal evaluation and recommendation to the central office for review and approval. The material submitted would include a copy of all proposals received. The carrier would simultaneously submit a copy of these materials to the servicing Medicare regional office. Upon receipt of these materials in central office, the Medicare review team reviews the carrier's evaluation of all proposals received to the extent appropriate to validate the carrier's conclusions. The review team then prepares an analysis paper of the carrier's evaluation for submission to the Medicare Director for approval.

When the carrier is notified of the Medicare Bureau's approval to award a subcontract, the successful vendor may proceed to implement the proposed system. The Medicare Bureau notice to the carrier would request the carrier to submit for approval a copy of the proposed contract between the carrier and successful vendor. When the proposed subcontract is received for approval, it is reviewed by the Medicare Bureau against the RFP and the successful vendor proposal to assure compliance with these documents and other requirements within the carrier Medicare agreement, executive order and public law.

In the Medicare program, the general policy is to require approval of all subcontract modifications if the subcontract originally required prior approval. The rationale for approving the modifications is based on the cost-no profit prime contract and the lack of incentives in the contracts. Since significant profits involving subcontracts can be made under the no profit prime contract, it is important to monitor these transactions. It follows that modifications of these subcontracts similarly require approval. To date, there has been no change in policy to approve modifications when the subcontract required approval.

Medicaid can only require approval of the final contract document for fiscal agent contracts since it only has authority to approve anticipated expenditures.

For MMIS systems design, development or installation at 90 percent FFP, provisions of 42 CFR 450.90 and Part 7-71-00 of the Medical Assistance Manual apply. Part 7-71-25 defines the types of documents required and the process for submittal and approval of these documents. Medicaid requires prior approval of the advance planning document, the request for proposal, the evaluation of proposals, selection of the winner, and the final contract.

Although Medicaid does not presently require approval of contract modifications, a policy is evolving to require such approval if any of three conditions occur. This policy states:

> "All basic contract changes and all subcontracts, which change the scope of work, increase the total cost, or extend critical dates in the approved contract will be submitted to HEW/HCFA for approval."

Options

1. Require that all contract documents and modifications be approved by HCFA.
2. Require only the contract to be approved by HCFA.
3. Require the contract and modifications to be approved by HCFA.

Advantages/Disadvantages

An advantage to reviewing only contracts is that the length of the procurement cycle would be shortened considerably; perhaps as much as 30-40 percent. This would contribute to earlier resolution of operational difficulties and/or program needs. Another advantage to such an agreement would be the administrative convenience afforded to Medicaid in not having to monitor the contracting procedures used in the States. A simple contract review is less costly and less trouble than reviewing and approving each step of a procurement. A similar advantage could be argued for the States--less Federal intervention into State procurement affairs, and less delay awaiting approvals to move to the next step. The State would not incur additional costs due to delays in receiving Federal approval. In addition, HCFA administrative costs might be reduced since fewer personnel would be needed in the review and approval process.

Limiting the review and approval by Medicare-Medicaid to the contract document, on the other hand, serves little purpose other than to disclose what is being purchased and for how much, and to ensure that the required social and other provisions are included. The basis for the contract is normally the RFP and the vendor proposal. These documents include the services to be performed and prices. The contract terms must be evaluated against the RFP and proposal and at that point changes are difficult, if not impossible, to accomplish.

Approving all contract documents would help to assure (1) a need for the contract/subcontract, (2) confidence in cost effectiveness or cost benefits of proposed contract/subcontract, (3) integrity of RFP and evaluation plan, and (4) integrity of proposal evaluation process and selection of successful vendor. It would help to promote competition between third-party vendors since bias toward any system or vendor would be minimized. It would also serve to maintain costs by limiting changes to those required and assuring that the proposed change would meet requirements of Medicare and Medicaid.

It is acknowledged that the review and approval process serves to extend the procurement cycle and to some extent increases agency operating costs. Increased emphasis on early detection of problems and advance planning should be placed upon the Medicare carriers and States so that delays in the procurement process do not adversely impact on operations nor affect program costs.

With respect to modifications, to forego approval of all contract/subcontract modifications is not indicated in either the Medicare or Medicaid program. While administrative burdens would be simplified by an absence of modification review, the possibility of excesses without review is too great to completely abandon the review process. Similarly, there is no overriding reason to approve Medicare subcontract modifications and allow Medicaid contracts to be modified routinely without review.

There is, and would continue to be, undue burden placed on all parties involved if a requirement is maintained to review all contract/subcontract modifications. It would be counter-productive by any measure to review minor modifications within certain limits, even when there are not obvious incentives in the contracts/subcontracts under consideration. The review of contract/subcontract modifications in certain instances holds the most promise of protecting the programs while permitting the States/carriers/intermediaries to operate freely without burdensome control by the Government.

2. Who should have the authority for prior approval of documents?

Current Situation

Medicare Prime Contracts: Central Office (authority to contract)
Medicare Subcontracts: Central Office
Medicaid Contracts: Regional Office
Medicaid Subcontracts: States
MMIS Contracts: Central Office

Under Sections 1816 and 1842 of the Social Security Act, the Secretary has the authority to enter into agreements (prime contracts). The authority has been redelegated to HCFA and resides in the Medicare central office.

The Medicare agreement requires carriers/intermediaries to obtain prior approval by the Secretary before entering into any subcontracts that would exceed specified monetary threshold amounts. These threshold amounts currently range from $50,000 to $165,000 and are based upon the contractor's total administrative costs. The Medicare Bureau's current delegations of authority limit the approval of data processing subcontracts to the central office and this was done principally to uniformly monitor and review the evolvement of new systems and because of the high costs involved in this area.

Medicaid currently has two different procedures for the approval of State documents as well as different requirements for which documents are required. For fiscal agent contracts the only document required for prior approval is the contract, and this approval is given by the Regional Medicaid Director if the contract amount is over $100,000. Below that no contract approval is required. For MMIS contracts, approval is required for all documents. While regional office review and comments are desirable, approval authority has always rested in central office.

Factors to be considered in either Medicare or Medicaid in determining where approval for contracts should rest would include (1) the availability of qualified technical, financial and contracting personnel in the approval component, (2) need for uniform approach, (3) monitoring of significant national activities that are in an evolutionary process, (4) need to assure opportunities nationally to third-party vendors involved in the activity, (5) sensitivity of activity in assuring effective program operations and (6) cost level.

Options

1. The regional offices should have the authority to approve all documents for both Medicare and Medicaid.
2. The regional offices should approve States' documents with respect to Medicaid contracts and the central office should approve all Medicare documents.
3. The central office should approve all Medicaid and Medicare contract documents.
4. The central office should develop guidelines for all contracting/subcontracting activities. The regional office would follow the guidelines in approving all documents. The central office would perform a post-approval review.

Advantages/Disadvantages

Because of their proximity to operational locations, the regional offices should be more aware of operational and program problems existing at Medicare contractor and State sites. This proximity should enable the regional offices to respond more quickly to existing problems and to act more quickly on materials requiring reviews and approvals. In many cases, the regional offices are located in the same city as the operation and personal visits are feasible to expedite processes.

Conversely, because of this proximity and familiarity with local operating situations there may be a tendency for regional offices to "tolerate" deviations from required procedures in their zeal to minimize operational disruptions; that is, they may tend to be less objective in their reviews.

Uppermost is the concern that regional offices would not normally be aware of the activities of firms offering systems services nationally, nor of the varied systems provided by the same firm or differing firms nationally. An offered system which may appear sophisticated in one geographic area may have been tried elsewhere and found ineffective. Related to this question of knowledge of systems nationally is a concern for costs. It would be expected that vendors would offer reasonably similar services for similar prices nationally. Regions normally would not be aware of what prices vendors were asking for similar services in other parts of the country.

On occasion, at least under Medicare, the Bureau is involved in resolving questions of cost, policy, technical requirements, etc.,directly with third-party vendors (in concern with the contractor). If this type of activity were handled on a local basis, each region conceivably could negotiate these varied issues at different levels of effectiveness, applying differing emphasis and approaches.

The review of RFPs issued by Medicare carriers and States is a highly specialized area requiring broad knowledge of technical requirements, cost considerations, and contract requirements. This expertise has evolved in central office and a small corps can effectively process the review of RFPs and evaluation plans nationally. Likewise, this same corps of expertise can assure uniform approach in reviewing carrier and State evaluations and selections of successful vendors. Systems firms who submit proposals in response to RFPs invariably sell and

service their wares nationally. Through a centralized review, the systems vendors could reasonably expect to have their proposals consistently and uniformly evaluated, even though the contract originates in different areas of the Nation.

3. Should time frames be implemented for approving documents?

Current Situation

Medicare Prime Contracts: Not applicable
Medicare Subcontracts: Timeframes
Medicaid Contracts: No timeframes
Medicaid Subcontracts: No timeframes
MMIS Contracts: No timeframes

At the present time, the Medicare Bureau has 60 days in which to approve or deny requests for prior approval of subcontracts. In practice this appears to be good, since it sets an outside time limit on the Bureau and requires each component to act within reasonable time limits in order to complete the evaluation within the 60 days.

Regarding timeframes placed on contractors for the completion of each step in the procurement process, the Medicare Bureau currently has no strict rules which the contractors must follow. There are, however, suggested timeframes which experience has shown will allow a quality job within reasonable timeframes:

RFP (Allow 2-3 months for preparation and release)

Preparation of RFP: 2 months
Review by Bureau: 2 weeks
Revision by Contractor: 1 month
Review and Approval by Bureau: 2 weeks
Printing and Release: 1 week

PEP (To begin at release date of RFP)

Preparation of PEP: 1 month
Bureau Review: 2 weeks
Contractor Revision: 1 week
Bureau Review and Approval: 1 week

This timeframe allows completion of the PEP during the 60 days awaiting proposals.

Evaluation of Proposals by Contractor: 2 months
Review and Approval of Award by the Bureau: 2 months
Implementation: 6 months

(During this period, work is usually begun under a short letter agreement. The actual contract is negotiated during this period with the Bureau being allowed 60 days for its review and approval.)

Medicaid has considered issuing regulations on the procurement process, including time allowed for various Federal approvals. These regulations, however, were never successfully put forth due to the many ramifications involved with dates of submittal, receipt, signatures, remailing, re-receipt, etc. To the States even 30 days seems a long time for approval of most documents, other than an entire evaluation package with evaluation reports, proposals, and proposed contract.

If the regional offices, and to a lesser degree the central office, are involved in the development of each required document, the final approval should be nearly pro forma. Only where high priority has been granted to high program dollar, high risk States (such as New York and California), have Medicaid approvals been within what the States consider reasonable timeframes. While Medicare has 60 days to grant approvals, and Medicaid may take that long or longer, it does not seem entirely reasonable when viewed from the State perspective. They are the ones on the line, the ones committed to several years of hard work on tight schedules, and it is unreasonable for them to mark time while a bureaucracy considers the acceptability of their work.

Options

1. Mandate timeframes.
2. Do not mandate timeframes.

Advantages/Disadvantages

Without timeframes, slippage tends to occur and this can be costly to both the States and the contractor/offeror.

Where the Medicare carrier desires the particular procurement, timeframes have generally not been necessary because the contractor stays on top of the situation. This is generally found in facilities management systems procurements where the carrier has been performing poorly and has reached the decision that the procurement is needed to upgrade performance.

Where the contractor does not particularly care to undergo the procurement, experience has shown that without timeframes and Bureau pressure for adherence, slippage is the rule. This situation is generally found where the carrier has a facilities management systems subcontract which is terminating and the carrier is satisfied with the existing arrangement and does not care to change.

INTEGRATION OF MEDICARE AND MEDICAID FUNCTIONS
UNDER A SINGLE CONTRACTOR

I. Statement of the Issue

Should the Health Care Financing Administration (HCFA) continue the present mode of separate contracting for intermediaries and carriers under Medicare and fiscal agents under Medicaid or should HCFA contract with a single contractor for administration of the Medicare and Medicaid programs?

A major consideration is the potential for improving overall program administration. Significant concerns involve (1) reducing administrative complexity, (2) more effective communication and service to the provider and beneficiary communities, (3) achieving more consistent application of policy where the same benefits are now being administered by Medicare and Medicaid, and (4) reducing and consolidating the number of contractors.

II. Discussion of the Issue

To establish the framework for the discussion of integrating Medicare and Medicaid functions under a single contractor, the individual program characteristics are described below. In addition, the impacts of combining specific contractor functions are also discussed.

A. Medicaid

Title XIX of the Social Security Act provides for a program of medical assistance for certain low-income individuals and families. The program, known as Medicaid, became Federal law in 1965. It succeeded earlier welfare-linked medical care programs, most notably the Kerr-Mills program of medical assistance for the aged. Medicaid will account for some $19 billion in Federal and State expenditures in fiscal year 1978, and is the primary source of health care coverage for the poor in America.

Title XIX requires that certain basic services must be offered in any State Medicaid program: inpatient hospital services, outpatient hospital services, laboratory and x-ray services, skilled nursing facility (SNF) services for individuals 21 and older, home health care services for individuals eligible for skilled nursing services, physicians' services, family planning services, rural health clinic services for individuals under 21 and early periodic screening, detection and treatment for children. In addition, States may provide a number of other services if they elect to do so,

including drugs, eyeglasses, private duty nursing, intermediate care facility services, inpatient psychiatric care for the aged and persons under 21, physical therapy, dental care, etc.

States determine the scope of services offered (they may limit the days of hospital care or number of physicians' visits covered, for example). They also, in general, determine the reimbursement rate for services, except for hospital care, where States are required to follow the Medicare reasonable cost payment unless they have approval from the Secretary of Health, Education, and Welfare, to use an alternate payment system for hospital care. Since July 1, 1976, they have been required to reimburse for skilled nursing facility and intermediate care facility services on a reasonable cost-related basis.

Since States generally determine the eligibility level for the welfare programs (they set the Aid for Dependent Children (AFDC) level, and determine the amount of supplement, if any, to the basic Federal Supplemental Security Income (SSI) payment), they exercise a great deal of control over the income eligibility levels for Medicaid. If they cover the medically needy, they may establish the income level for eligibility at any point between the cash assistance eligibility level for an AFDC family (adjusted for family size) and 133-1/3 percent of the payment to such an AFDC family. All of these variations--in benefits offered, in groups covered, in income standards, and in levels of reimbursement for providers--mean that Medicaid programs differ greatly from State to State.

Medicaid operates as a vendor payment program. Payments are made directly to the provider of service for care rendered to an eligible individual. Providers must accept the Medicaid reimbursement level as payment in full. Individuals, however, are required to turn over their excess income to help pay for their care if they are in a nursing home. Copayments may also be required in limited circumstances.

Many members of the Medicaid population are aged or disabled, and are also covered under Medicare. In cases where this dual coverage exists, most State Medicaid programs pay for the Medicare premiums, deductibles and copayments, and for services not provided by Medicare.

States participate in the Medicaid program at their option. All States, except Arizona currently have Medicaid programs. The District of Columbia, Puerto Rico, Guam and the Virgin Islands also provide Medicaid coverage.

States have the option of administering their Medicaid program inhouse or contracting with a "fiscal agent" to perform certain program functions such as claims processing and claims payment. States may use a fiscal agent to perform these functions for all services or only specific services (e.g., drugs, dental, etc.). Currently 18 States maintain total inhouse programs, 21 States use fiscal agents for some services and 14 States use fiscal agents for all services.

B. Medicare

The Medicare program is a Federal health insurance program for people 65 or over, and for disabled beneficiaries and persons with chronic renal disorders. The program was established by Congress in 1965, when it enacted Title XVIII of the Social Security Act. The Medicare program consists of two distinct parts. Hospital Insurance, or Part A, of the program covers expenses of medical services furnished in an institutional setting, such as a hospital or skilled nursing facility, or provided by a home health agency (HHA). Medicare Insurance, or Part B of the program covers physician services and certain other medical equipment and services.

In 1965, when the Medicare program was enacted, the Government adopted a program alignment similar to that used by Blue Cross/ Blue Shield Associations furnishing services to their membership: intermediaries, Blue Cross Plans servicing hospitals, SNFs, etc., and carriers, Blue Shield Plans servicing physicians, laboratories, etc. The adoption of this structure was compatible with the historical pattern of administration used by the health insurance industry and helped to insure a quick and smooth implementation of the Medicare program.

As part of the administrative arrangement, the Government under Section 1842 of the Act, assigned geographic service areas to a mix of private and public insurance companies (carriers) to handle physician services. However, under Section 1816(a) of the Act, a different arrangement was established for dealing with hospitals, SNFs and HHAs. Under this provision, a group or association of providers designates an intermediary through whom they wish to deal with the Government. Upon notice to the Secretary, the provider may change the intermediary; thus, the provider has the flexibility to "shop" for an intermediary that meets its needs. The Government could terminate the service of an intermediary or not renew the contract; however, the Government could not assign the providers to a particular intermediary, since to do so would violate their legal rights under the nomination

provision. Under Section 14 of Public Law 95-142, providers may be assigned or reassigned to intermediaries when the Secretary feels that it is in the best interest of effective and efficient program administration. In concert with the reassignment process, the intermediary has an appeal right where a provider is assigned to another intermediary by the Secretary. The intermediary appeal provision of Public Law 95-142 will delay the reassignment of a provider.

In administering the Part B Medicare program, carriers are responsible by law for determining the reasonable charges to be allowed for covered services. In administering the Part A Medicare program, intermediaries are responsible by law for determining the reasonable cost to be allowed a provider for providing covered services. Currently, Medicare contracts with 77 intermediaries and 46 carriers to administer the program.

C. Contractor Functions

In general, Medicare and Medicaid contractors perform the same basic functions relating to eligibility, benefits, claims processing, reimbursement, utilization review, fraud and abuse, and beneficiary and provider relations. The following section discusses the impact of combining these functions under a single contractor for both the Medicare and Medicaid programs.

1. Eligibility

At the present time, the Social Security Administration establishes initial eligibility for the Medicare program and the State establishes eligibility for the Medicaid program. The contractor, however, must verify the beneficiary's eligibility with each program before making any program payments. If the administration of the Medicare and Medicaid programs was combined under a single contractor, the contractor would still need to separately verify eligibility with the State and/or the Social Security Administration. Cost savings could be obtained by maintaining one file for cross-over claims. If common identifiers were used for Medicare and Medicaid beneficiaries, increased efficiency in the administration of cross-over claims would be obtainable. Any real cost savings would only be obtainable by standardizing eligibility between the two programs.

2. Benefits

The Medicare and Medicaid programs differ widely in the type, scope and duration of benefits provided. Furthermore, each State Medicaid program provides its own unique combination of benefits. Unless benefits were standardized between the two programs, administrative costs may not decrease under a single contractor. In the short run, costs might actually increase while the new contractor became familiar with the program benefits for which it was not previously responsible.

3. Claims Processing

Combining the claims processing function of Medicare and Medicaid under a single contractor could result in administrative cost savings as well as provide a potential for program savings. Administrative cost savings could be realized by eliminating duplicative hardware, software, and personnel. Increased workload could produce economies associated with large scale operations. Use of one contractor could also facilitate implementation of a common claim/billing form, common provider/beneficiary identification numbers, common procedure coding terminology, and common pre and post edits. Implementation of these items plus a common data base would enhance utilization review and fraud and abuse activities which should result in decreased program costs.

4. Reimbursement

Under the current reimbursement methods and rates which differ for Medicare and Medicaid, reimbursement of providers and beneficiaries by a single contractor would result in minimal administrative cost savings: one check instead of two could be issued to a common Medicare-Medicaid provider and a combined explanation of benefits for cross-over claims could be sent to beneficiaries. Additional costs could be saved through closer monitoring of provider allocation of costs, common audits, more uniform cost settlements and better control of duplicate payments. If statewide fee schedules, mandatory assignment, common accounting systems among providers, and common reimbursement principles for Titles XVIII and XIX were implemented then use of a single contractor would produce substantial administrative and program cost savings.

5. Utilization Review

Combining the utilization review function for Medicare and Medicaid under a single contractor would provide the opportunity for establishing single profiles of providers and detecting clearer practice patterns. It also creates the potential for increased denial of claims and elimination of duplicative billings, thus decreasing program costs. In addition, a more efficient and effective relationship with Professional Standards Review Organizations (PSROs) could be established.

6. Fraud and Abuse

The availability of single provider and beneficiary profiles under one contractor could promote better development of fraud and abuse cases and decrease the number of "washouts" on preliminary investigations. The potential for a more aggressive fraud and abuse effort may increase administrative costs but would result in greater program cost savings.

7. Beneficiary and Provider Relations

Combining the beneficiary and provider relations function under a single contractor for Medicare and Medicaid will decrease confusion, increase the programs' public image, lower contractor travel and personnel costs, and provide the opportunity for more efficient administration through common or combined billing forms, and uniform provider/beneficiary procedures.

To summarize, significant administrative cost savings may be obtained over time from combining the claims processing function under a single contractor. Administrative costs savings from combining the other six contractor functions would be minimal. On the other hand, significant program cost savings could result from combining utilization review and fraud and abuse under a single contractor.

III. Summary of Options

There are four strategic options with respect to the integration issue. The first option is to continue the present arrangement for handling the administration of Medicare and Medicaid. The second option is to study different integration approaches through experimentation. The third option is to integrate Medicare and Medicaid functions on a voluntary basis. The fourth option is to mandate integration.

The advantages to integration have been previously discussed under contractor functions and thus will not be reiterated below. Instead, the advantages/disadvantages of implementing each option with respect to a strategy for integration are described.

In order to compare options, the second, third and fourth options are based on the following assumptions:

- the contractor will perform all administrative functions except those relating to the determination of eligibility, benefits and reimbursement rates,
- State boundaries will be used as the building blocks for contractor jurisdictions,
- combined Title XVIII and XIX contracts will be phased in over time to coincide with the expiration of existing Medicare and Medicaid contracts,
- combined Title XVIII and XIX contracts will be awarded on a competitive basis,
- combined Title XVIII and XIX contracts will be for a 4-year period which includes a 1-year start-up period and a 3-year operational period.

IV. Discussion of Individual Options

Option 1: Continue the present arrangement of administration for the Medicare and Medicaid programs

Under this option, Medicare and Medicaid are considered as two separate programs, one totally administered by the States, the other by the Federal Government. There would be, however, a continuation of the current efforts to combine common elements such as claim forms, coding procedures, and cost settlements. Within each program, there would be greater emphasis on improving program administration. Medicare would continue its initiatives at consolidations of workloads along geographic lines, improve cost performance via the increased use of competition, and improve operations via the use of performance criteria and standards. Medicaid would continue its initiatives at more accurate program payments via the increased use of Medicaid Management Information System (MMIS) and the use of such programs as the "corrective action programs."

Advantages

Under this option, the States maintain control and accountability of their Medicaid program. The Federal Government retains control over Medicare. Thus, the expenditure of program dollars is controlled by the responsible authorities within each program. This option recognizes that there are fundamental differences between the programs which make them hard to effectively integrate. Maintaining the present management would avoid severe disruption to the programs. Furthermore, the current competitive market environment among contractors would be maintained.

Disadvantages

A substantial number of people (approximately 15 percent) are eligible for both programs. The provider community is basically the same for Medicare and Medicaid. Even though providers and a large number of recipients are the same for both programs, they have to deal with two separate programs with different procedures and rules. This is cumbersome for them and costly for the Government. As a result of these differences, there is great difficulty in combining program data. By maintaining separate contractors, the opportunity to benefit from the economies associated with large claims processing operations is diminished. Moreover, duplicative data processing systems, physical plants and administrative structures are tolerated. In addition, cost savings which could result from integrated fraud and abuse efforts would be lost.

Option 2: Experiment with different approaches to integrating the administration of the Medicare and Medicaid program

This option is to study and experiment with the various ways in which the administration of Titles XVIII and XIX could be combined without committing the Government to integration on a national basis.

Advantages

This option would provide an opportunity to test the feasibility of integrating the Medicare and Medicaid programs. Although it appears that integration would produce significant cost savings it may not be viable. The findings of the experiments would determine whether HCFA should take further action toward national integration.

If the results of the experiment indicate that integration is feasible and cost effective, the administrative procedures and

operational techniques necessary for nationwide implementation will have been developed. If integration does not appear feasible, integration can easily be abandoned.

Experimentation also provides the opportunity to find the best method for integration. By testing different models, HCFA would not be nationally committed to a particular integration approach and thus could easily discontinue a particular version if it proved unworkable. Different types of models which might be considered include:

- the State Medicaid program and Medicare would each contract separately with the same contractor to operate an integrated system,
- the State would contract with the Federal Government for the State to operate the Medicare program,
- the State and the Federal Government would jointly award a contract to a single contractor to administer the Medicare and Medicaid programs on an integrated basis,
- the State would contract with the Federal Government who in turn would award a contract to operate both the Medicare and Medicaid programs.

Another advantage to experimentation is that it would reduce the risk of an expensive false start toward national integration. It would also allow time to build a political base in Congress for any new legislation and to permit the industry lead time in developing the necessary resources prior to national integration.

Disadvantages

Since participation in any experiment would be voluntary, States may choose not to participate. In addition, delay of full integration provides the States and current Medicare contractors an opportunity to organize and resist permanent change. Furthermore there may be no cost savings to the programs if the States under the experiment switched back to separate program contractors at the end of the experiment, since start-up and conversion costs for integration are substantial. A final disadvantage might be lack of competition due to the small pool of potential contractors who would be capable and willing in a short period of time to invest the necessary resources to gear up for an experiment. Many organizations would not be willing to take the substantial risk. Thus many present contractors may eliminate themselves from the marketplace while others would be precluded from entering it.

Costs/Savings

Conducting experiments in a maximum of five States for a period of 4 years at current Federal financial participation (FFP) for Medicaid levels would result in an estimated net administrative cost of $32-57 million; at 75 percent FFP net administrative costs would be approximately $76-101 million. Administrative costs include start-up, conversion of systems, phase-out of existing contractors, evaluation of experiments and additional administrative and salary and expense costs. Increased matching may have to be given to the States as an incentive to join the experiment.

Timetable

An initial model could be developed by 1979, and operational in 1980, where State participation is voluntary. This is based on the assumption that legislative changes are not needed for changes in Medicaid administrative matching rates. If legislation is needed, the experiment could be operational 1 year later, 1981.

Feasibility

Legislative Considerations

It appears that a joint Medicare-Medicaid experiment could be conducted under existing authorities.

Administrative Considerations

It is possible to use existing States and Federal administrative structure; however, administrative procedures would need to be developed, e.g., statement of work, performance standards and criteria, monitoring procedures, etc.

Budgetary Considerations

Additional funds would need to be requested if FFP were increased to 75 percent.

Political/Social Considerations

In order to generalize the findings of the experiments nationally, specific types of States would need to participate (e.g., large/small, urban/rural, high/low percentage of cross-over claims, etc.). Sufficient inducements to States, such as increased matching, guaranteed cost savings and/or "hold harmless" agreements would be necessary to get the "right" States to voluntarily participate in the experiments.

Option 3: Integrate Medicare and Medicaid functions on a voluntary basis

Under this option, States would on a voluntary basis enter into agreements with the Secretary who would contract to combine the administrative and operational functions of the Medicaid and Medicare programs. Unlike the experiments, there would be no limit as to the number of States which could participate. Legislation would be required.

Advantages

This option puts the States and Medicare contractors on notice that the Federal Government is moving toward functional integration of Medicare and Medicaid without major disruption to either program. It leaves the decision to integrate to the States and allows them the opportunity to join "the bandwagon" at their own pace. Since few States would decide to integrate immediately potential contractors would have time to develop the necessary resources and capacity to competitively bid on the majority of contracts. Furthermore, since a voluntary approach would be an ongoing operational mode rather than an experimental mode, more organizations would be willing to make the investment and take the necessary risks to compete. This option would maintain the competitive marketplace.

Disadvantages

States may choose not to participate since they will be reluctant to relinquish any control over their Medicaid program funds. If only a few States participated, the administrative complexity of managing two different types of contracting arrangements would be increased. Furthermore, the current Medicare and Medicaid contractors in States which switched to an integrated system would probably challenge contract awards through administrative and legal appeals and thus delay implementation. Total integration would not be achieved.

Costs/Savings

The following costs/savings are based on 15 States voluntarily deciding to integrate the functions of their Medicaid and Medicare programs. Administrative costs include start-up, conversion of systems and phase-out of existing contractors. During the first 4 years of a voluntary program the estimated net administrative costs would be $49-115 million at current FFP and $130-196 million at 75 percent FFP. However, during the second 4 years the programs could realize a net administrative

savings of $114 million at current FFP and only a $32 million cost at 75 percent FFP. Thus, over an 8-year period there would be an administrative cost savings of $0-65 million at current FFP or a cost of $162-228 million at 75 percent FFP.

Steps Required for Implementation

- Legislative and regulatory changes are needed in Medicare's nomination process and contractor reimbursement method and in Medicaid's matching rates for administrative costs.

- Refinement of administrative procedures to include model contracts, work standards, uniform cost forms and administrative procedures.

Timetable

The timetable for implementing the voluntary approach is relatively short for those States using fiscal agents. Legislative changes, which could be enacted by 1980-81, are the key to implementing this option. While legislation is enacted, State interest and administrative procedures can be acted upon.

Feasibility

Legislative Considerations

Most of the legislative changes are technical because they deal with streamlining administration. State resistance should be minimal since participation is voluntary. Increased administrative match will be partially offset by program savings.

Administrative Considerations

The following administrative procedures must be addressed:

- model contract including detailed statement of work,

- performance criteria, contractor monitoring procedures, and performance penalties,

- single site data processing resources,

- method of accounting for and transferring State funds.

Budgetary Considerations

Administrative budget for Medicaid would increase because of increases in the matching rate.

Political/Social Considerations

State concerns should be minimal since participation is voluntary. Present State fiscal agents and current Medicare contractors may oppose the plan based on potential loss of work.

Option 4: Mandate integration of Medicare and Medicaid functions

Under this option, the Federal Government would mandate that all States integrate the functions of their Medicaid programs with Medicare under a single contractor. The States would not have the option of participation. Legislation would be required to implement this option.

Advantages

Mandating integration eliminates two contracting arrangements for managing the Medicare and Medicaid programs which reduces administrative complexity. In addition, the number of contracts to be administered would be decreased making administration easier and less costly. Furthermore, combining the administrative processes into one mode facilitates the implementation of health care policy changes. Administrative and legal appeals by current contractors would be avoided since integration would be mandated and different contracting arrangements eliminated.

Disadvantages

Mandating the merger of Medicare and Medicaid functions may be politically difficult because States will not want to relinquish control over and accountability for the expenditure of State Medicaid program dollars. If States currently administer the Medicaid program inhouse, the switch to a contractor may cause unemployment. The limited number of qualified contractors presently in the marketplace who have the capacity to handle an integrated contract may prohibit adequate competition. HCFA would not have the flexibility of exploring different administrative procedures and operational techniques to determine which are most efficient and effective.

Costs/Savings

Administrative costs include start-up, conversion of systems and phase-out of existing contractors for all States. During the first 4-year period estimated administrative net costs would be $172-403 million at current FFP and $455-686 million at 75 percent FFP. However, during the second 4-year period a net administrative savings of $400 million would be realized at current FFP. At 75 percent FFP there would be a $12 million cost.

Steps Required for Implementation

In order to implement this option, legislation authorizing HCFA to integrate the Medicaid and Medicare functions under a single contractor must be enacted. The contractor community must be given the time to amass the capital necessary to build the required capacity to perform the combined functions. HCFA must put into place an administrative structure to implement and monitor the contractor process. It will be necessary to develop administrative procedures for the contractor process, monitoring of the work performed, assessment of penalties, replacement of contractors, etc.

Timetable

Implementation cannot be rapidly accomplished. The contracting process, both phasing-out current contracts and initiating new ones is very complicated. It will take some time to put in place the Federal administrative structures and to develop the necessary control and monitoring processes. Agreements must be reached with each of the 54 Medicaid jurisdictions on the control and accountability for their Medicaid funds. The States will need time to dismantle their Medicaid administrative structures and to adjust their staffs. The contractor community will need time to build the capacity for processing the integrated workloads.

All the above steps are dependent upon the passage of the appropriate enabling legislation. For the most part, they can be implemented parallel to each other, and are not dependent on steps other than the legislative authority. It will take approximately 3 years from the passage of legislation to implementing this option in the first jurisdiction.

Feasibility

Legislative Considerations

Congress must pass the necessary legislation. The States must be willing to give up an element of control over their Medicaid programs in exchange for increased Federal payment of administrative costs.

It must be remembered that the State savings will come as a result of reducing the State work force, with a concurrent increase in the Federal side.

Budgetary Considerations

Implementation of this option will require large expenditures to phase out current Medicaid and Medicare processing contracts, to build the industry capacity to process the joint workloads, and to build the needed Federal administrative structure.

Political Considerations

The States are going to be very reluctant to give up control of their Medicaid programs and their funds. There may be a displacement of State employees. State justifications for present and future large computer centers would be reduced. Moreover, States would lose their chief source for funding the centers--Federal matching under the Medicaid program. The local medical communities will fight against dilution of their power in influencing State Medicaid policy. There will be a politicalization of the contracting process. States will push for the processing centers to go to in-State firms, while the larger contractors will seek to influence the contracting process.